THERAPISTS: FROM FAMILY TO CLIENTS

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Abstract

As a paradigm of a wounded healer, parentified therapists may be gifted with therapeutic talents, but also with related vulnerabilities that may have a significant influence on their therapeutic practice. Therefore, the aim of the current study was to explore the impact of parentification on therapeutic practice, especially on the therapeutic skills of empathy and boundary settings. For this purpose, a mixed method design was employed in which 38 trainee psychologists provided self-report data on the constructs of parentification measured by parentification questionnaire (Jurkovic, 1997), empathy, measured by Interpersonal Reactivity Index (Davis, 1980), and boundary settings, measured by Exploitation Index (Epstein, 1990) in a survey study, while 4 trainee psychologists were interviewed in a separate study. First, the quantitative data were analysed to assess the existence of possible relationships among the variables of parentification, empathy and boundary transgressions by a regression analysis. The results offered significant suggestions for the predictive power of parentification in regard to empathy and boundary transgressions. Following this, a qualitative study analysed the interviews with the 4 trainees using thematic analysis to explore the above relationships and provided a deeper insight, especially for their therapeutic utility. Combining the findings, the current study supported that parentification may first of all catalyse the choice of a psychologist's profession, well as the choice of the psychotherapeutic approach. In regard to the interpersonal skills, parentification may positively impact the development of enhanced levels of empathy, boundary flexibility, and creativity. On the other hand, parentification may also negatively impact on practitioners by making them more vulnerable to enmeshed therapeutic relationships. Especially in the case of destructive parentification, professional support may be needed to minimise the risk for enmeshed relationships, by increasing self-care and self-other differentiation. Clinical implications for parentified therapists were also discussed.

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Dedications

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It is also dedicated to my father, who taught me how to be proud of myself, as he is always proud of me.

Therapists: From family to clients

Literature Review

Viktor Frankl emphasised the wisdom and meaning that each of us can extract from painful experiences (1963). Long before theoretical and clinical frameworks were established, personal experience was the most valued guide in the service of healing others (Jackson, 2001). The idea of the wounded healer implies that it is essential for therapists to have a personal experience of being wounded in order to be able to heal (Jackson, 2001). According to Bennett (1979), the importance of the wound lies in its capacity to inspire empathy, and understanding. In other words, personal experience of being wounded may increase the capacity for being compassionate and sensitive to other people's wounds.

However, critics of this concept have argued that the therapist's woundedness could hinder the therapeutic process due to the inherent problems associated with the wound. Issues associated with personal wounds, such as narcissistic injuries, unmet emotional needs, unresolved conflicts and dysfunctional relational patterns can transfer into the therapeutic relationship in the form of countertransference and jeopardise the therapeutic process (Barnett, 2007; Cain, 2000; Gelso & Hayes, 2007). Thus, if the emotional wounds of the therapist go unattended, this can compromise therapeutic objectivity and effectiveness (Gelso & Hayes, 2007). It seems that the therapist's own wounds and healing experience can provide an important therapeutic tool, but at the same time can create a barrier to therapeutic effectiveness. The purpose of the current literature review is to shed some light on the above debate by presenting theoretical and empirical resources that could contribute to a deeper understanding of the topic.

The wounded healer

Writings on the wounded healer can be traced back in mythology and philosophy. In the Greek myth of Asclepius and Chiron the Centaur, as well as in the shaman philosophy, healers incorporated treatments based on their own recovery (Cain, 2000). In the Greek myth of Chiron, the centaur was shot with a poisoned arrow, which caused a great wound. His wound was incurable, so Chiron voluntarily relinquished his immortality and died (Stone, 2008). Chiron's wound symbolises the transformative power of illness and affliction. Through pain and suffering, his personal wounds transformed themselves into sources of great moral and spiritual strength.

In addition, shamanism is a traditional idea in which a shaman is the person who has suffered and has the ability to serve others as a healer (Jackson, 2001). The shaman needs to experience personal wounds and initiate the path of healing with the help of Spirits. It is the journey of personal suffering and healing, which provides the wisdom to work with the spirits in order to assist the healing of others (Goldberg, 1993). Thus, the wounded healers will use their own journey of healing as a point of reference to guide others. Through personal suffering, the wounded healer learns how to overcome his pain and transcend it into knowledge.

In the field of psychology, the most influential figures, such as Freud, Jung and Frankl, were among the most consummate models of a wounded healer. Their autobiographical accounts revealed numerous emotional struggles and troubled histories which significantly inspired and shaped their theoretical approaches to treatment (Jackson, 2001). Freud emphasised the importance of the therapist's healing process by emphasising personal analysis and therapy (Freud, 1912). Similarly, Frankl's personal suffering in the concentration camps and his personal search for meaning during suffering inspired the

creation of his logotherapy. He supported that it is the personal exposure to despair which provides the means to transform this experience into the art of healing (Frankl, 1988).

Apart from the significant figures in psychology, a contemporary representation of the wounded healer concept was the movement of Alcoholics Anonymous (A.A.). In A.A. recovered alcoholics become sponsors by incorporating their personal knowledge of recovery to support and guide new members. Becoming a sponsor is recognised as an important component of recovery and maintenance of abstinence for the sponsor himself, emphasising the health-enhancing effects on the healer (Jackson, 2001)

Moreover, Groesbeck (1975) provides a description in his effort to explain the therapeutic process in terms of the wounded healer. He emphasises an interactive process in which both members of a therapeutic relationship undergo internal transformations (Groesbeck, 1975). In other words, the therapeutic relationship activates mutual projections of vulnerability and healing in both healer and client. Then, the healer's experience of the healing process restores the projections, and helps himself and the client to undergo a therapeutic transformation. In addition, Sussman (1992) emphasised that the importance of woundedness is apparent in the development of a deep empathy for the pain in others, by recognising the pain of suffering. The therapists' own woundedness seems to provide an inner point of reference which fosters the ability to connect and empathise with clients at a deeper level.

The incidents of woundedness in helping professions

In the research on the wounded healer, studies have already identified the prevalence of woundedness in helping professionals. Therapists have been found to have higher incidence of traumas and difficult childhood experiences in comparison to other non-helping professionals (Barnett, 2007; Casement, 2006; DiCaccavo, 2002; Dryden & Spurling, 1989;

Dunne, 2000). In these studies, role reversal/ parentification was just one of a number of traumatic experiences that are found to be prevalent amongst therapists (Burton, 1972; DiCaccavo, 2002, 2006; Fussell & Bonney, 1990). For instance, Fussell and Bonney (1990), in a comparative study among psychotherapists and physicists, found that psychotherapists reported higher negative evaluation of childhood experiences, a higher incidence of parental absence, communication ambiguity, parent-child role inversion and caretaking role.

Similarly, DiCaccavo (2002) found that counselling psychology trainees reported significantly lower levels of care from their mothers but reported higher levels of self-efficacy towards caring in comparison with art students. More recently, Nikcevic, Kramolisova-Advani and Spada (2007) found that psychology students with clinical aspirations reported higher prevalence of childhood sexual abuse, parentification and a negative home atmosphere in comparison with psychology students with no clinical aspirations, and business students.

Further, early traumas and difficult childhood experiences have also been interpreted as motivating factors for entering a mental health career. Unmet needs of intimacy, validation and support may seek indirect expression and reparation through therapeutic relationships (Dryden & Spurling, 1989). For example, Barnett (2007) identified the themes of early loss and narcissistic needs as sources of influence for becoming a therapist. Menninger (1957) proposed that therapists who have experienced some form of early rejection may project their own needs into clients, and care for themselves indirectly, where professional practice becomes a process of self - healing. Further, Sussman (1992) endorsed that the motivating factors to enter the therapeutic profession can be grouped in three categories. The first category relates to instinctual aims, both libidinal and aggressive, which can manifest as a desire to heal, rescue or even reject the client. The second category relates to the early development of the self, referring mainly to narcissistic needs, which can manifest as the

therapist's need for validation and acceptance by clients. In addition, the third category is referred to unresolved issues with relatedness, which can manifest themselves by dependency or by controlling therapeutic relationships.

Parentification as an early wound

As has been mentioned above, parentified experiences have already been found to be prevalent in the early histories of mental health professionals (Nikcevic et al. 2007). Throughout the literature, numerous terms have been used to describe the same process, such as role-reversal, parentification, parental child, and overburdened children, which complicates the study of the phenomenon and the comparisons among research findings (Chase, 1999; Minuchin, 1974; Rosenbaum, 1963). Parentification is described as a familial relational pattern in which children are assigned responsibilities which parents in a particular family have abdicated (Mika, Bergner, & Baum, 1987). In other words, parentification is conceptualised as the structural boundary distortion in which the child is forced into a parenting role and burdened with parental responsibilities (Chase, 1999). In some cases, this familial boundary distortion aims to compensate for parental deficiencies and tries to maintain familial homeostasis (Jurkovic, 1997). Children become responsible for instrumental tasks, such as keeping the house clean, preparation of meals, caring for siblings, and earning money, as well as for emotional tasks, such as providing emotional support, and becoming the family advisor. Moreover, parentification is conceptualised as a continuum emphasising both its healthy and unhealthy nature, encompassing infantilisation, non-parentification, adaptive parentification, and destructive parentification (Jurkovic, 1997). Based on Jurkovic's classification (1997), infantilisation occurs when the child under-functions and parents strive excessively to meet all his/her needs, whereas the care giving behaviour of the child is at a lower level. At the non-parentification level the child's care

giving behaviour is according to his or her developmental stage, and it is acknowledged and supervised. Still, in this process the boundaries among family subsystems are not distorted and there is not parental reliance on children.

With regard to adaptive and destructive parentification, Boszormenyi- Nagy and Spark (1973) emphasised an important difference by proposing that parentification under some conditions is not inherently pathological. Adaptive parentification is likely to occur if the parental reliance on the child is time-limited, age-appropriate, perceived as fair by the child and recognised by parents (Jurkovic, 1997; Jurkovic, Kuperminc, Sarac, & Weisshaar, 2005). Then, parentification may enhance the child's development by offering the opportunity to experiment with adult tasks and responsibilities. Some studies have already supported the adaptive nature of parentification proposing that it contributes to the development of empathy, adaptive copying skills, and responsibility (Stein, Rotheram-Borus, & Lester, 2007; Tompkins, 2007). On the other hand, destructive parentification is characterised by the lack of reciprocity, age-inappropriateness, lack of recognition, and extended responsibility (Chase, 1999).

Moreover, the major factors that have been identified as determinants for the differentiation between destructive and adaptive parentification are the age appropriateness of the role, the fairness, the extent of responsibility, the recognition, the length, and the level of internalisation (Jurkovic, 1997; Jurkovic et al., 2005). Specifically, when the support that is needed is beyond the child's developmental capacity, and is perceived as unfair or not recognised, then the parentification will most probably lead to destructive impact. In addition, whether the child will identify itself with a parentified role and internalise it as a self-representation will also determine the destructive or adaptive nature of parentification.

Reviewing the literature, studies have mainly identified as a crucial precursor of parentification parental unavailability, which can result from the absence of parents through

divorce, death, excessive work, mental and/or physical disability (Aldridge & Becker, 2003; Burnett, Jones, Bliwise, & Ross, 2006; Goglia, Jurkovic, Burt, & Burge-Callaway, 1992; Johnston, 1990; Jurkovic, Thirkield, & Morrell, 2001; Sroufe & Ward, 1980). Clearly, the above familial circumstances compromise parental resources and create a need for additional support.

In addition to parental unavailability, studies have also focused on certain characteristics of a child, such as age, gender and maturity. With regard to gender differences, traditionally, the female role has been associated with care-giving behaviour; however the research findings with regard to such gender differences remain unclear. Some studies support the idea that females are highly associated with care-giving roles in contrast to males and are at higher risk for parentification (Burnett et al., 2006; Mayseless & Scharf, 2009). Similarly, Hiester (1995) proposed that maritally distressed mothers were more likely to promote spousification with their sons and parentification with their daughters. In turn, daughters are more likely to accept care-giving roles in comparison with sons. In contrast to these findings, other studies did not find significant gender differences to be an important factor for parentification (Castro, Jones & Mirsalimi, 2004; Johnston, 1990).

Additionally, the same research ambiguity exists with regard to a child's birth order and maturity. Some studies have supported that older children are at higher risk of parentification in comparison to younger ones (East & Weisner, 2009; Levine, 2009; McMahon & Luthar, 2007). However, other studies proposed that a child's level of maturity may override birth order and put younger children in the same risk category for parentification (Jurkovic, 1997). Consequently, more research is needed in order to clarify the child's characteristics that may increase the risk for parentification.

Moreover, another risk factor that has been identified by the research is the intergenerational transmission of parentification. Hazen, Jacobvitz, and McFarland (2005)

argued that boundary disturbances, such as role reversal, may transmit across generations. Similar, Jacobvitz, Morgan, Kretchmar, & Morgan (1991) found that women who had experienced overprotective parenting or enmeshed relationships with their parents were interfering with the autonomous development of their own child. As Boszormenyi-Nagy and Spark (1973) explained, enmeshing patterns of interaction may pass from one generation to another, in order for parents to relive their lost childhood through their children. Consistent with this, family theories also support that early relational patterns are carried forward as a mental representation of the self and others, leading to repeating patterns of relationships among generations (Sroufe, Jacobvitz, Mangelsdorf, & Ward, 1985).

Beyond the predisposing factors, important theoretical contributions have been made to explain the process of parentification. Miller (1995), in her book 'The Drama of Being a Child', explained that children in their effort to secure parental love, which will guarantee their existential security, will employ all their available resources to respond to the parental needs (Miller, 1995). The child becomes attuned to parental needs and learns to display characteristics favourable to its demands and inhibits the ones that are unwelcome.

Miller used Winnicott's term of false self to describe this conditional identity and explained that the child cannot develop a true self, as it is discouraged by the environment to discover it. To put it differently, the expression of the true self will remain undeveloped, concealed and protected, as in not validated and accepted, whereas the child will learn to relate through a false self to secure relations with parents. In essence, the child tries to satisfy the relational needs of his or her parent in order to secure his personal existence (Miller, 1995). At this point, the boundaries between parent and child are beginning to distort, as the child begins to incorporate the ideology of a significant other before self (Miller, 1995).

Further, Miller used Mahler's separation-individuation theory to explain how parentification hinders the development of independent self, as it lacks the responsive

environment that will encourage the child to go through the normal symbiotic phase to the separation-individuation phase (1995). In essence, the lack of parental attunement, mirroring and validation interrupts the rapprochement phase in which the child moves between staying connected with the mother and going away from her, compromising the development of an autonomous self. Then, Miller (1995) proposed that grandiosity and depression are two defences which may operate to compensate for the fragile true self.

In addition, attachment theory provides another theoretical framework which can explain the process of parentification. Attachment theory has described how infants attach to their mother for safety and comfort and use her as a secure base for further exploration (Bowlby, 1988). It seems that in parentification, children lack the secure base, which can provide them with the safety needed in order to explore their environment and develop an autonomous self. Instead, they are preoccupied with trying to maintain proximity to attachment figures (Byng-Hall, 2002). Therefore, children's care-giving can be considered as a behavioural strategy to secure proximity to parents (West & Keller, 1991). Also, attachment theory supports that early interaction with care-givers leads to the development of mental representations or internal working models which could be used as a template for interpreting further relationships (Bowlby, 1988; Byng-Hall, 2002). Following this line of thought, parentified children may develop a caretaker self -representation which can be transferred into their future relationships (Hazen et al., 2005).

The impact of parentification

Numerous studies have identified the destructive impact of parentification leading to important considerations for the child's development. With regard to personality, parentification is able to predict self-defeating and/or narcissistic personality characteristics, defensive splitting and shame-proneness in adulthood (Jones & Wells, 1996; Wells & Jones,

1998, 2000). Specifically, Jones and Wells (2000) postulated that in parentification, unrealistic parental demands maybe internalised as an ego ideal, which the child may strive to accomplish. However, the unrealistic nature of the ego ideal will inevitably lead to failure to meet those standards, accompanied by feelings of shame related to the inadequacy of the self. Therefore, parentification, as an early relational experience may lead to the development of a self-schema which perpetuates the negative view of the self, regardless of contradictory evidence (Baldwin, 1992).

Moreover, Robinson and Kelley (1998) found that parentified individuals may develop a work-addicted style, using competence as a condition of self-worth. In addition, studies proposed that parentified adults tend to display characteristics of perfectionism by setting unrealistic standards for themselves, which may inevitably make them susceptible to self-criticism and low self-worth (Castro et al., 2004; Glickauf-Hughes & Mehlman, 1995).

Further, Jones and Wells (2000) proposed that children use the process of splitting in their effort to defend against the feelings of shame. Through splitting parentified children may develop a grandiose self and project the devalued self onto others, showing narcissistic traits, or may develop a devalued self and project the ideal characteristic onto others, showing masochistic traits (Wells & Jones, 2000). In support of self-defeating traits, Valleau, Bergner and Horton (1995) have also found a significant relationship between parentification and caretaker syndrome. The caretaker syndrome, as it is described by the authors, refers to individuals who feel compelled to help or rescue others, who find it difficult to detach from others' difficulties, who are reluctant to receive support, and who tend to ignore their own needs (Lerner, 1989; Valleau et al., 1995). The researchers concluded that parentified adults may continue to practise care-giving behaviour despite their own needs, in comparison with non-parentified adults. Similarly, West and Keller (1991) also suggested that parentified individuals tend to assume the role of nurturer, mediator, organiser, protector at the expense

of their own needs. In addition, Winton (2003) proposed that parentified individuals' need for approval may lead them to excessive care giving roles, which in turn decreases their ability to set limits in relationships. Further, parentification has been associated with the impostor phenomenon in which the person feels fraudulent and unworthy, living in a constant fear of failure (Castro et al., 2004).

With regard to the impact on an individual's emotional well-being, Jacobvitz and Bush (1996) measured depression and anxiety symptoms in parentified adults, and found that mother-daughter triangulation (alliance) leads to anxiety symptoms, whereas father-daughter triangulation (alliance) was related to symptoms of depression. In addition, Jacobvitz and Sroufe (1987) conducted a longitudinal study and verified that parentification during early years is linked with attention deficit disorder, difficulties in adjustment, and social problems in early school years.

In a more recent study, Shifren and Kachorek (2003) found that 42% of the parentified participants had high depressive scores, and that the duration of the care giving role was positively correlated with current mental health issues. In addition, Rowa, Kerig, & Geller, (2001) found that early role-reversal particularly with fathers, was associated with eating disorders in young adult women. Further, Hooper, DeCoster, White, and Voltz (2011) conducted a meta-analysis in order to examine the magnitude of the relation between self-reported parentification experienced in childhood and psychopathology. They found a significant positive link between childhood parentification and adult eating disorders, anxiety, and personality disorders. Moreover, Schier et al. (2011) found that emotional parentification is a risk factor for symptoms of depression and somatoform pain in adulthood.

With regard to interpersonal functioning, Katz, Petracca and Rabinowitz (2009) found that early role reversal with parents was related to excessive reassurance seeking and attachment anxiety in romantic relationships. Moreover, Byng-Hall (2008) argued that

parentified children may transfer the pattern of responsibility they experienced as children to other relationships by adopting the role of caretaker.

Furthermore, Levine (2009) found that individuals who were destructively parentified during childhood exhibited higher levels of parentified behaviour towards their nuclear family of origin as adults, and experienced greater distress in intimate relationships. Additionally, Bourassa (2010) supported that parentification was associated with high care giving and insecure attachment to romantic relationships, as well as with higher levels of depressive symptoms. She concluded that parentification in the family of origin may be transferred as a relational pattern in romantic relationships. Similarly, Wells, Glickauf-Hughes, & Jones (1999) argued that parentification was related to the tendency of acting as a caregiver rather than an equal partner in adult relationships.

Aside from the destructive impact on an individual's well-being, other studies have highlighted the positive impact of parentification, providing evidence for its adaptive form. However, the research which focuses on the benefits that parentification promotes to child development is limited. Some research shows that early care giving may enhance the development of maturity, self-reliance, and empathy (Chase-Lansdale, Wakschlag, & Brooks-Gunn, 1995; Goodnow & Lawrence, 2001). Studies have also found that adaptive parentification may contribute to positive self-esteem, feelings of interpersonal competence and psychosocial adjustment (Brubaker & Wright, 2006; Burton, 2007; Kuperminc, Jurkovic & Casey, 2009; McMahon & Luthar, 2007; Thirkield, 2002). Walsh, Zvulun, Bar-On, & Tsur (2006) found that parentification was associated with high levels of individuation, family cohesion, and self-mastery when it is perceived as fair by the child and is age appropriate. In addition, Tompkins (2007) found that emotional parentification engendered closeness between parent and child, positive parenting, and child adjustment among families coping with a serious medical condition. Moreover, Hooper, Marotta, and Lanthier, (2008)

supported that parentification was positively related with posttraumatic growth. Overall, these studies support that parentification cannot be considered as inherently pathological. On the contrary, appropriate challenging and the assignment of age-related responsibilities may reinforce the development of the child and increase his or her level of competence.

Taking into consideration both perspectives of adaptive/destructive nature, parentification seems to have a bimodal impact. On the one hand, parentification could promote the child's development and competence under the appropriate conditions, such as age appropriateness, fairness, and time limitation. On the other hand, under inappropriate conditions, parentification can be proved detrimental to the child's well- being.

Theoretical considerations of the talents and vulnerabilities of wounded healers

Taking into account the relational capacities that psychologists need to withhold, brings into question how all the aforementioned influence of parentification may catalyse professional practice. Therapeutic relationships may activate important relational dynamics which can then trigger through countertransference therapists' unresolved conflicts. Narcissistic or masochistic traits, impostor feelings, low self-esteem, the need for validation and compulsive care giving that may stem from parentified experiences may influence the role that a therapist holds in a therapeutic relationship and jeopardise the therapeutic process (Glickauf-Hughes & Mehlman, 1995; Jurkovic, 1997).

Miller (1995) raised an important concern that unless parentified therapists have worked through their past, they can be in danger of transferring their early exploitative relationship with their parents to clients. Unconsciously, parentified therapists may try to fulfil unmet narcissistic needs for validation and approval by calling the clients to meet these expectations. Then, a client may become trapped in this dynamic, and operate as a good and compliant client in order to secure this alliance, which may further encourage a conditional

presence of the self for the client. The above process, between therapist and client seems to mirror early parentification processes.

Another important consideration for parentified therapists may be the tolerance of therapeutic uncertainty which may become challenging for their fragile self-esteem, especially when the therapeutic success may be considered an important condition for the maintenance of the ideal self (Mollon, 1989). It is at this point that the therapeutic relationship can become enmeshed, as the therapist's self-worth is dependent upon the therapeutic success (Glickauf-Hughes & Mehlman, 1995). In addition, the therapist's need for acceptance may compromise the expression of a client's negative transference in fear of damaging the narcissistic collusion between therapist and client (Halewood & Tribe, 2003). Similarly, parentified therapists may face difficulties in containing the client's reactivity when setting concrete limits (Jurkovic, 1997). It is then possible that the therapeutic boundaries can become especially loose, in order to minimise the client's disapproval and retaliation. In addition, the parentified therapist's relational patterns of compulsive care giving may also re-enact in order to minimise the client's disapproval, which may further infantilise the client (Glickauf-Hughes & Mehlman, 1995; Valleau et al., 1995). In other words, when the therapist is driven by needs of personal gratification he or she may lose sight of his or her therapeutic objectivity and thereby compromise therapeutic effectiveness.

In contrast to the vulnerabilities that the impact of parentification may bring to therapeutic practice, it is possible that this early role may enrich the individual with important talents for practice. In terms of the wounded healer paradigm, parentification may become an important experience which may increase the individuals' understanding and insight making him/her an important candidate for the therapeutic profession. Moreover, Jurkovic (1997) proposed that parentification may offer important therapeutic gifts to individuals, such as humanness, resourcefulness and wide clinical range. In addition, he suggested that parentified

therapists may have developed increased therapeutic skills and abilities as they have early on trained to be sensitive to the emotional needs of others and to provide support. The early experience with parentification may have developed in them higher capacities and resources for engaging with emotionally vulnerable people.

Methodological Considerations of parentification

From reviewing the literature, important considerations were raised with regard to measurement of parentification. In relation to parentification, the measurement through the literature has been conducted mainly by using three different approaches, including self-reports, projective tests and observational methods. Among self-reports, the Parentification Questionnaire (PQ-A) is a 42 item self-report instrument developed by Sessions and Jurkovic (1986) with college students measuring instrumental and expressive parentification during childhood and adolescence. The questionnaire is reported to have good psychometric properties and test-retest reliability (Jurkovic, 1997).

Furthermore, the parentification scale was developed by Mika in collaboration with college students in order to assess different parentified roles across two periods: before age 14, and between the ages of 14 and 16 (Mika et al., 1987). The test takes into account the age and the extent of parentification. Both self-report questionnaires base their ratings on the ability of the participants to recall childhood experiences. This is a significant factor in the limitation of this design of measurement, as it can put the validity of the test in question (Chase, 1999). Similarly, the validity of the test can be at risk due to the subjectivity of an adult's judgment upon their childhood parentification. Another major limitation of both measurements is that they are not taking in account the socio-cultural and family conditions from which the parentification developed (Chase, 1999).

Moreover, observational studies overcome the validity limitations that self-reports have by measuring parentification in a more direct manner. The role of "child-in dispute and role reversal scale" developed by Johnston, Gonzalez, and Campbell (1987) rates the degree of a child's involvement in marital conflict as well as the type of parentification tasks, giving the scale average interrater reliability. In addition, the "dissolution of generational boundaries scale" by Sroufe et al. (1985) rates the tendency of parents to support their children on a given task, as well as the tendency to relate to them as parents or as peers, giving the scale a very good interrater reliability. A significant limitation of observational studies is that they are prone to measurement reactivity, as it is possible that participants may tend to behave differently when they are observed. Measurement reactivity in combination with the lack of well-established operational definition for parentification can prove a major obstacle (Chase, 1999).

Moreover, projective measurement decreases the possibility of socially acceptable responses by measuring parentification in indirect ways. The main projective measurement of parentification is the "child-as-parent" and "child-as-mate" by Walsh (1979). The test takes scenarios from the "thematic apperception test", and measures the role of child-as-parent and child-as-mate, without taking into consideration the factors that make parentification destructive. Therefore, even if the inter-rated reliability is very good, it does not measure parentification as a whole (Chase, 1999).

In conclusion, all measurements used to assess parentification until now have significant limitations that must be addressed. Primarily, there is a need for a common operational definition of parentification that will account for the factors and conditions that influence the phenomenon. Furthermore, most of the measurements lack differentiation between emotional or instrumental parentification. In addition, most of the measurements used to not take in consideration factors that make parentification destructive, such as age

appropriateness, internalization, boundaries, social legitimacy, ethicality, role assignment, and the extent of responsibility. Still, all the measurements assess individuals' perception of a parentified experience and they lack further validation from other family members, such as parents. Therefore, most of the instruments measure parentification tendencies, rather than the direct phenomenon. Additionally, most of the measurements that have been introduced are not standardised for clinical settings (Chase, 1999)

Taking into consideration the above limitations, across the different measures of parentification the Parentification questionnaire (PQ-A) was preferred for the purpose of this study as it captures emotional parentification, instrumental parentification and perceived fairness (Chase, 1999). The PQ-A is a 42 item self-report instrument developed by Sessions and Jurkovic (1986) with college students measuring an overall score of parentification during childhood and adolescence. The PQ-A measures retrospectively, the subjective experience of caretaking responsibility between child and parents in the family of origin. Sessions and Jurkovic (1986) state that the higher the score, the higher the degree of parentification. A clinical cut-off has not been established, therefore parentification was treated as a continuous variable in the current study. However, Jurkovic (1997) suggested that individuals' scores as measured by PQ-A should be interpreted relative to their deviation from the mean of the sample from which the individuals' scores were drawn. Consequently, the above suggestion is used only as a way to describe and interpret the trends of the current data.

Concluding remarks and the current research

Overall, the idea of the wounded healer has emphasised the journey of personal healing as an important therapeutic tool. The awareness of being wounded, the experience of undergoing the pain and its successful resolution are essential landmarks in the experience of a healer, which may increase his/her abilities to contain a client's suffering and facilitate the healing process (Jackson, 2001). Therefore, parentification as a manifestation of a wound may have the same implications for therapists. It is possible that parentified therapists may have cultivated important therapeutic abilities through their personal experience of healing parentification. Conversely, if the destructive parentified experience goes unattended this may compromise their therapeutic effectiveness.

However, research is still in progress as to how the unattended impact of destructive parentification can manifest itself in the therapeutic practice. Even though there are theoretical considerations for the impact of parentification on therapeutic skills, the related empirical research is still scarce. Taking into consideration past literature, it is possible to consider that the adaptive form of parentification may enhance the therapeutic capacities of parentified therapists, in contrast to the destructive form of parentification, which may compromise their therapeutic abilities. In the light of this, the current study aims to explore the impact of parentified experiences on therapeutic practice, and especially on the therapeutic skills of empathy and boundary setting.

For the purpose of this study, a mixed method design was employed to examine the relationships between parentification, empathy and boundary transgressions. The employment of both quantitative and qualitative data was used in order to gain a deeper understanding and offer different perspectives on the same phenomenon. Following the philosophy of pragmatism, the methods are chosen as the best way to serve the multidimensional nature of the research questions (Creswell, 2003). In other words,

quantitative methodology will illustrate the objective relationships in early parentification and the therapist's levels of empathy and boundary transgressions, but may lack the context and meaning that qualitative methodology could offer. Taking into consideration the variations in parentified experiences, and their corresponding impact on the therapist, a qualitative study was employed in order to take into account all observations no matter how deviant from the 'norm' they are (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005). Therefore, different data collection techniques were used to cancel out the method effect and to increase confidence in the conclusions (Masadeh, 2012). In other words, a mixed method design would provide a richer portrait of the complex impact of parentification on therapeutic practice, and will offer an increased strength and validation to the conclusion, more than one method alone could provide (Gelo, Braakmann & Benetka, 2008). Furthermore, the employment of a mixed method will provide an objective knowledge that is derived from the measurement of the current variables, as well as a subjective knowledge that is derived from analysing the experience of the participants (Masadeh, 2012).

In the light of this, the following pieces will present the introductions, methods, results and discussions of both qualitative and qualitative studies, as well as the combining discussion and conclusion, followed by a critical appraisal of the whole research.

The Wounded healer: Parentification and the interpersonal skills of empathy and boundary setting.

Introduction

A substantial body of evidence indicates that the therapeutic relationship is one of the most influential factors in determining therapeutic outcomes (Lambert, 1992; Norcross, 2002). The importance of the therapeutic relationship lies in the fact that it has the potential to offer a reparative experience of a functional relational pattern (Teyber, 2010). In other words, the therapist needs to provide an alternative response that does not fit the old schemas and disconfirms the relational expectations of the client. This new response will provide an experiential re-learning of a new relational pattern, which can be internalised and transferred to other relationships (Teyber, 2010).

However, the therapist's ability to provide a reparative interaction may be influenced by his or her own relational patterns (Mallinckrodt, 2010). For instance, Mohr, Gelso, and Hill (2005) have supported that counsellors with dismissing attachment style report hostile, critical, and rejecting countertransference with preoccupied clients, whereas counsellors with preoccupied attachment style reported this type of countertransference behaviour with dismissing clients. Thus, the client's relational pattern may contradict and challenge the counsellor's own relational pattern, making the reparative process especially difficult.

Additionally, empathy and boundaries are widely accepted as important interpersonal tools for reparative therapeutic relationships (Greenberg, Elliot, Watson & Bohart, 2001; Jensen, Weersing, Hoagwood, & Goldmuan, 2005). In practice, a reparative interaction requires a therapist to find the right balance between empathy and boundaries with each client. That is to say, that the ability of the therapist to maintain professional boundaries and at the same time, remain empathic with the client is a very challenging task. With

unrestrained empathy there is a danger of boundary violation and confluence, while being detached may indicate a desensitisation to the client's situation (Teyber, 2010). Thus, the therapist needs to have the capacity to balance the relational skills of relatedness and separateness in order to provide a reparative therapeutic relationship. Following these ideas, the practitioner's relational patterns may become crucial, especially in the way they may influence the appropriate use of empathy and boundaries.

Parentification, as a relational pattern, has already been found to be prevalent in the childhood experiences of some practitioners (Fussell & Bonney, 1990; Lackie, 1983). However, few studies have examined the direct impact of parentification on practitioners' therapeutic skills, even though relevant findings have suggested that parentification may have a detrimental impact on interpersonal functioning (Jurkovic, 1997). In other words, even though there are theoretical considerations for the impact of parentification on therapeutic skills, the related empirical research is still scarce and the effects of parentification on therapeutic practice are mostly speculated. For the aforementioned reasons, the aim of the current study was to examine the impact of parentification on the practitioner's relational functioning, focusing on relational skills important for therapeutic relationships, such as empathy and boundary settings.

As has already been discussed, parentification refers to a premature adoption of parental roles, which vary with regard to the quality, quantity, and perceived fairness of the role (Boszormenyi- Nagy and Spark, 1973). Parentification is conceptualised as a continuum reflecting the degree of its occurrence (Jurkovic, 1997).

Overall, numerous studies have supported the destructive impact of parentification; however, some studies have also provided evidence for its adaptive nature. Taking into consideration both aspects, Hooper et al. (2011) argued that low levels of parentification may be beneficial, whereas high levels of parentification may account for the commonly reported

link between parentification and psychopathology. In other words, moderate occurrence of parentification may entail the appropriate level of challenging that promotes an individual's further development. Whereas, high occurrence of parentification goes beyond appropriate challenging to overburdening that may compromise further development.

Nevertheless, the most prominent interpersonal consequences of parentification are suggested to be excessive caretaking in adult relationships, co-dependency, perfectionism, low self-other differentiation, low emotional regulation, immature object relations, self-defeating traits and narcissistic personality styles (Chase, Deming, & Wells, 1998; Fullinwider-Bush & Jacobvitz, 1993; Jones & Wells, 1996; Valleau et al., 1995; Wells & Jones, 2000). In contrast, studies providing evidence for the adaptive impact of parentification found a mild level of post traumatic growth, enhanced capacities of emotional understanding, better adaptive coping skills, positive self-esteem, and increased competence (Brubaker & Wright, 2006; Chase-Lansdale et al., 1995; Fitzgerald, 2005; Jurkovic, 1997; Kuperminc et al., 2009; Stein, Rotheram-Borus, Lester, 2007; Titzmann, 2011; Thirkield, 2002). Taking into consideration the destructive and adaptive influences of parentification, it seems probable that parentified therapists may demonstrate vulnerabilities as well as strengths in relation to their empathy and appropriate boundary setting.

Reviewing the first interpersonal skill that this study aimed to explore, it became obvious that through the literature numerous definitions have been given on empathy. However, recent findings from neuroscience support Kohut's idea, who envisions empathy as an emotional and cognitive process (1984). Thus, empathy entails a cognitive aspect: the understanding of another's emotional state, as well as an emotional aspect: the sharing of the emotional state of another. In practice, the appropriate use of empathy offers to clients the feeling of being understood, accepted and validated by the therapist. In psychotherapeutic terms, empathy has been describe by Rogers as feeling and understanding the client's private

world without losing the ‘as if’ condition (1957b). In other words, the therapist enters the client’s world in order to feel and understand it, without however losing objectivity.

With regard to measurement, the various definitions of empathy lead to the use of different measures, which make the comparisons among findings more difficult to interpret (Gerdes, 2011). For instance, some studies define empathy as a cognitive process, using measurements which address only the cognitive aspect, whereas, other studies define empathy as an emotional process with measurements corresponding only to its emotional aspect (Gerdes, 2011). Therefore, the different operational definitions of empathy complicated the comparisons among findings.

Overall, the most widely used measurements in the literature are self-reports, due to their convenience and cost-effectiveness. The disadvantage of this type of measurement is that it relies on self-assessment which can be biased due to social desirability, and memory distortions. The most widely used questionnaires have been Hogan's empathy scale which measures only the cognitive aspect of empathy (Hogan, 1969), Mehrabian and Epstein's questionnaire which measures only the emotional aspect of empathy (1972), and, Davis's Interpersonal Reactivity Index (IRI) (Davis, 1980) which measures both cognitive and emotional empathy. The IRI is designed to assess the multidimensional nature of empathy and it is considered the most comprehensive assessment of empathy (Cliffordson. 2002). In addition, the IRI has been applied with similar populations to psychology trainees, such as counsellors (Constantine & Gainor, 2001; Hatcher et al., 2005) and medical professionals (Bellini & Shea, 2005; Galantino, Baime, Maguire, Szapary, & Farra, 2005). Consequently, the IRI was the preferred scale for the current study, as it conceptualises empathy as both cognitive and emotional process.

To be precise, Davis conceptualises empathy as the function of four distinct components. The empathic concern component has been defined as the other-oriented

feelings of sympathy and concern (Davis, 1983). Empathic concern is viewed as a dimension of empathy, which describes the ability to focus on other people's distress (Lange & Couch, 2011). In addition, empathic concern has been associated with secure attachment, and high self-esteem (Joireman, Needham & Cummings, 2002a). The second component, perspective taking, has been defined as the tendency to spontaneously adopt the point of view of others (Davis, 1983). The ability to understand the perspective of others is also considered a positive aspect of empathy. Perspective taking has also been associated with secure attachment and low interpersonal problems (Joireman, Parrot, & Hammersla, 2002b; Lange & Couch, 2011). Moreover, the fantasy component has been described as the tendency to transpose themselves imaginatively into the feelings of fictitious characters (Davis, 1980). The last component of empathy, personal distress, has been described as the self-oriented feelings of personal anxiety in tense interpersonal settings (Davis, 1983). Personal distress is considered as a maladaptive aspect of empathy and has been associated with anxiety, low self-esteem, emotional vulnerability and interpersonal problems (Davis, 1983; Lange & Couch, 2011). Davis (1983) supported that the scales are measuring different constructs, as there are not significant associations among the four aspects of empathy.

However, two different positions emerge in the literature with regard to the IRI's applications. Some studies have measured the different dimensions of empathy separately (Davis, 1994), whereas other studies have calculated an overall score by summing up the subscale scores (Burkard & Knox, 2004; Burke, 2001; Moriarty, Stough, Tidmarsh, Eger & Dennison, 2001; Webster, 2002). The second approach is consistent with the second-order hierarchical model of empathy validated by Cliffordson (2002), who argues that empathy consists of a single global dimension. Moreover, some researchers have supported that personal distress is a separate construct from empathy and have defined it instead as an empathic response (Batson, Fultz, & Schoenrade, 1987; Eisenberg & Fabes, 1998; Pulos,

Elisonjh, & Lennon, 2004; Scheiman & Turner, 2001). In support of this, Pulos et al. (2004) analysing the hierarchical structure of the IRI, have suggested that a higher-order empathy scale could be derived from a simple sum of the EC, FS, and PT subscales. Following the above suggestions, the current study obtained an overall score of empathy by excluding the construct of personal distress.

Moreover, proceeding to research findings, parenting has already been recognised as a defining factor for the development of empathy. Affection and responsiveness provided by early caregivers play a crucial role in the development of empathy in children (Barnett, 1987). Accordingly, parentification as a parenting style that lacks responsiveness and attunement to the child's needs could lead to lower levels of empathy.

While this may be true, comparable findings from adult attachment studies provide evidence for opposite effects. Wilcoxon, Walker, and Hovestadt (1989) found that the lower the perceived autonomy and intimacy in the early childhood experiences of counsellor trainees, the higher their interpersonal facilitation skill level. In addition, Zahn-Waxler and Radke-Yarrow (1990) found that children living with depressed mothers were highly attuned to the problems of others. Further, Trusty, Ng, and Watts (2005) found that counsellor trainees who were high in anxiety and low in avoidance had the highest levels of empathy.

Although parentification was not measured directly in the above studies, still insecure attachment is found to be very prominent in parentified individuals (Chase, 1999). To put it differently, the emotional attunement that parentified children offer to parents may partly satisfy children's needs for closeness, but parental unresponsiveness will not gratify children's need for support, leading to attachment anxiety (Henry & Holmes, 1998; Katz et al., 2009). In addition, Fitzgerald (2005) focused on the impact of parentification on children's emotional development, and found that parentified children showed greater awareness of their mother's emotions. Overall, evidence stemming from the above studies

suggests that parentified therapists may display high levels of empathy, despite their early empathic deprivation. This raised the first hypothesis of the current study that parentification may predict a positive relationship with empathy, meaning that the higher the level of parentification the higher may be the degree of empathy.

As has already been mentioned above, an increased empathic capacity may enhance the ability of the therapist to be receptive to the client's emotional needs and to accommodate therapeutic boundaries accordingly. However, Weisshaar (2008) maintained that when the therapist feels too deeply for a client he may face challenges in the personal style of therapy, and in balancing the wants and needs of the different people in the therapeutic relationship. In addition, very high levels of empathy may lead to over identification with the client, which will inevitably compromise the maintenance of appropriate therapeutic boundaries (Omdahl & O'Donnelln, 1999). In support of this, Corcoran (1982, 1983) examined empathy along with the concept of emotional separation and found that higher empathic resonance was associated with lower levels of emotional separation. Following this idea, low emotional separation may implies a boundary distortion between the self and other. However, a strong sense of self, as separate from other, increases the ability of the therapist to disentangle his or her emotional state from the emotional state of the client, which allows for a more objective perspective (Gerdes, Segal, Jackson, & Mullins, 2011). The importance of an objective perspective lies in the ability of the therapist to set the appropriate boundaries without being drawn into the emotional world of the client. Therefore, the current study hypothesised, that empathy may predict a positive relationship with boundary transgression, over and beyond parentification, meaning that the higher the levels of empathy, the higher will be the corresponding levels of boundary transgressions.

Beyond empathy, professional boundaries are the second therapeutic skill that the current study aimed to explore. Professional boundaries are seen as a continuum, ranging

from detachment (rigid and inflexible rules), to enmeshment (flexibility to diffusement) (Corey, 1996). In therapeutic practice, boundaries determine the limits that protect the space between the therapist's power and the client's vulnerability (Peterson, 1992). The practitioner uses empathy in order to understand and contain the client's feelings, where in this process the boundaries between the self and the other become loose. However, when boundaries are becoming too loose, it may put in danger a client's identity and autonomy. Research on the destructive impact of boundary violations found links with depression, post-traumatic stress disorder, suicidal thoughts, increased drug and alcohol use, break-up of relationships and trust issues in clients (Kluft, 1989; Luepker, 1999).

Furthermore, boundary transgressions exist on a continuum ranging from adaptive (ethical and constructive), to maladaptive (unethical and destructive) (Zur, 2007). Boundary crossings are minor deviations from traditional clinical practice, which neither harm nor exploitation is involved (Halter, Brown, & Stone, 2007). In contrast, boundary violations are harmful and exploitative deviations (Zur, 2007). Most of the existing research has focused on sexual boundary violations, giving little attention to boundary crossings, even though a repeated pattern of boundary crossings has been proposed to lead to boundary violations on the slippery slope argument (Guthiel & Gabbard, 1993, Pope, 1990).

Boundary crossing is a very controversial area, as the limits are still vague and diverse across therapeutic modalities. Among the most ambivalent boundary crossings are the therapist's self-disclosure, touching, bartering, fees, length and location of sessions, contact outside the office and the exchange of gifts between therapists and clients (Guthiel & Gabbard, 1998). Studies on boundary crossing found that that under appropriate circumstances it leads to increased support, repaired self-esteem, increased trust, and decreased violent behaviour in clients (Cornell, 1997; Dunne, Bruggen, & O'Brien, 1982; Lambert, 1991; Lazarus & Zur, 2002; Norcross & Goldfried, 1992). Supporters of the

beneficial outcomes of appropriate boundary crossings have criticised the slippery slope position, arguing that this reasoning is fallacious as it does not prove causality between boundary crossing and boundary violations. However, fear of getting onto such a slippery slope might lead to rigid setting of boundaries, which may jeopardise therapeutic effectiveness (Gottlieb & Younggren, 2009). However, as there are not specific guidelines for appropriate boundary crossing, it remains subject to clinical and professional judgement.

Moreover, the difficulty in differentiating between boundary crossing and violations is also reflected in the scarcity of scales measuring boundary transgressions. The Exploitation Index seems to be the only questionnaire that is designed to serve as an early indicator of boundary violations (Hamilton & Spuril, 1999). According to Hamilton & Spuril (1999) the Exploitation Index is the only measurement that has undergone any type of formal psychometric evaluation. Thus, this tool was chosen for this study because it measures both sexual and nonsexual predictors for boundary violations.

The exploitation index aims to warn therapists that they may be in danger of transgressing boundaries with a client (Epstein & Simon, 1990). The Exploitation Index refers to seven subcategories of boundary transgressions: generalized boundary violations, eroticism, exhibitionism, dependency, power seeking, greed, and enabling. Generalised boundary transgressions refer to any role conflict or dual relationship. Eroticism contains questions relating to sexual boundary violations and a therapist's romantic feelings toward a client. Exhibitionism examines boundaries in regards to obtain personal gratification from client. Dependency category refers to any form of dependency in a therapeutic relationship. Power seeking includes questions that have to do with power imbalance between therapist and client. Greediness refers to issues involving benefits that a therapist can earn from clients. Finally, enabling refers to a therapist's need to rescue the client which manifests in making exceptions with clients (Epstein & Simon, 1990).

Moreover, Epstein and Simon (1990) administered the Exploitation Index to 532 psychiatrists and found that 43% of participants reported that one or more of the questions on the Exploitation Index alerted them to the possibility that they may transgress a boundary with a client. Of these, 29% of participants reported that the questionnaire motivated them to make specific changes in future treatment practices to guard against any boundary transgression that may arise. Epstein and colleagues propose that an EI cut off score of 27 or higher would characterise a high risk category, although they suggest that it lacks further validation (Epstein et al., 1992). However, for the purpose of this study, the EI was used as a continuum running from boundary crossing to boundary violations, according to the frequency of transgressions. Therefore, the cut off score will only be used as an indicator for the description of the results, and not for distinguishing between participants among groups.

One important consideration regarding the interpretation of the Exploitation Index is that some questions included in the questionnaire could be considered ambivalent with regard to their ethical nature in therapy. For instance, the category of generalised boundary includes the question of whether the clients address each other on a first name basis, or in the category of eroticism there is a question asking whether the therapist has ever touched a client. As has already been mentioned, some boundary crossings under the appropriate conditions can be considered therapeutic for the client (Lambert, 1991; Lazarus & Zur, 2002). Nevertheless, most studies on boundary transgression focus on its sexual aspect, whereas other aspects of transgression are less well known. Therefore, the EI was the only known available measure, which allowed for inferring a link between parentification and boundary transgression in general, not just its sexual aspect. This indicates the need for a valid measurement of boundary transgression with the ability to distinguish between boundary crossing and violations.

Another area of interest focused on studies searching for practitioners' characteristics that may increase their vulnerability to boundary transgressions. The scarcity of relevant studies is mostly limited to issues related to sexual boundary violations. With regard to demographic characteristics, studies support that age, gender, and experience seem to play an important role in boundary violations.

Boundary violations seem to increase with age and years of experience. For instance, Epstein, Simon, and Kay (1992) report that psychiatrists in the age group of 45-52 years report more exploitative behaviours than psychiatrists in the age group of 27-36 years. Similarly, Rodolfa et al (1994) propose that psychologists over 44 years tend to display higher incidence of sexual boundary violations than younger psychologists (under the age of 44 years). A possible explanation for the above findings is that ethical judgement seems to decline with age and experience (Borys & Pope, 1989; Epstein et al., 1992). In addition, therapists with more years of experience tend to display more boundary violations in comparison with less experienced therapists (Lamb et al., 1994, Borys & Pope, 1989). Stake and Oliver (1991) reported that less experienced psychologists were more likely to define sexually suggestive behaviour as misconduct in comparison with more experienced psychologists. Still, with regard to gender, males tend to commit a higher rate of boundary violations in contrast to females (Lamp et al, 1994). Taking these factors into consideration, the current study recruited trainee psychologists to participate in this study in order to reduce age and experience as confounding variables.

Moreover, few studies have focused on the characteristics and predisposing factors of the therapists with sexual boundary violations. Among others, Celenza (1991, 1998) supported that common issues among offending therapists are low self-esteem, restricted awareness, therapists' boundary transgressions by a parental figure, unresolved anger, narcissistic vulnerabilities, intolerance of negative transference, and distortion of

countertransference (Assalian & Ravart, 2003; Celenza & Hilsenroth, 1997; Luchner, Mirsalimi, Moser, & Jones, 2008; Norris, Gutheil, & Strasburger, 2003).

The above characteristics of therapists violating boundaries seem to share common factors with characteristics of parentified therapists, such as narcissistic vulnerabilities, low self-esteem, intolerance of negative transference and boundary transgressions by a parental figure (Chase, 1999; Jurkovic, 1997). This raises the idea that parentified therapists who display the above characteristics may be especially vulnerable to enmeshed therapeutic relationships with blurred professional boundaries (Halewood & Tribe, 2003; Stone, 2008). In support of this, Jurkovic (1997) proposed that parentified therapists in their efforts to compensate for early emotional deprivation and narcissistic injuries might seek self - affirmation in therapeutic relationships. Similar, Glickauf-Hughes and Mehlman (1995) supported that parentified practitioners may have difficulty setting limits and boundaries with clients. In addition, family systems and attachment theories have also proposed that parentification may lead to the development of a maladaptive schema based on enmeshed relationships, which may be carried forward to other relationships (Baldwin, 1992; Byng-Hall, 1991). Research supporting this notion found that mothers who reported role reversal in their family of origin tended to engage in higher levels of role reversal with their toddler-aged daughter (Hazen et al., 2005; Jacobvitz et al., 1991; Macfie, Mcelwain, Houts & Cox, 2005). Accordingly, parentified therapists may be vulnerable to transferring enmeshed relational patterns to their therapeutic relationships by violating professional boundaries.

In addition, Barnett (2007) interviewed nine psychodynamic therapists about their histories and he concluded that early loss and narcissistic needs might lead to self-sacrificing patterns and a need to become idealised parent-figures to patients. In turn, by seeking to satisfy their unmet needs for acceptance, these therapists may jeopardise their therapeutic relationships especially in the presence of a client's negative transference, which will

challenge even more the therapist's values (Dickinson & Pincus, 2003; Luchner et al., 2008). Attempts to reduce the client's negativity and disapproval may potentially compromise therapeutic boundaries.

Further, parentification is believed to affect the normal process of differentiation of self where the child becomes an object to a parent's emotional needs, undermining the development of an independent self. Valleau et al. (1995) found that parentified adults display this early relational pattern in other relationships in a form of over-responsibility for others and diminishing their own sense of self. Accordingly, parentified individuals may lack the protective factor of self-other differentiation, making them more vulnerable to emotional enmeshment and boundary distortions with clients. For these reasons, the current study hypothesises that parentification may predict a positive relationship with boundary transgression, meaning that the higher the experience of parentification, the higher may be the degree of boundary transgressions.

In addition, the above hypothetical suggestion of a positive relationship reflects also the idea that parentification in its adaptive level may be associated with boundary crossings instead of boundary violations. The adaptive influences of parentification, such as increased resourcefulness, high interpersonal problem-solving skills, and empathic potential, may enhance the ability of therapists to be flexible and innovative in the way they construct therapeutic boundaries. In support of this view, observations on parentified children showed an increased ability to respond creatively when dealing with emotional difficulties of others (Chase, 1999). Similarly, Jurkovic (1997) ,based on his clinical experience, speculates that parentified therapists due to their early competence may be less inhibited by the formal structure of the therapy situation and more willing to challenge and accommodate therapeutic boundaries for the best interest of their client. In addition, Zahn-Waxler and Radke-Yarrow (1990) found that children living with depressed mothers, apart from being highly attuned to

the problems of others, were also able to generate different strategies to resolve interpersonal problems. In other words, early competence may increase parentified therapists' ability to go beyond conventional practices. Their increased creativity may expand their capacity to establish an ideographic therapeutic approach with flexible boundaries according to the complexity and uniqueness of each client.

To summarise, the current study hypothesises that parentification may contribute to an increased capacity for empathy and flexibility of boundary setting, which may make individuals excellent candidates for the profession of psychotherapy. However, as the destructiveness level of parentification increases, then the difficulty of maintaining therapeutic boundaries may increase too. In addition, empathy may have also the ability to predict variations in boundary transgressions, over and beyond parentification, by assuming that higher degrees of empathy would correspond to higher degrees of boundary transgression.

The current study

The purpose of the current study was to examine the relationship among therapists' parentification, empathy and boundary transgression. A questionnaire study was used in order to gain a deeper understanding of the impact of parentification on therapists' empathy and boundary transgressions. Participants for this study were recruited from different counselling psychology training courses. The choice of trainees as participants was to help increase the internal validity of the study by eliminating the influence of age and experience as possible confounding variables (Bohart &Greenberg, 1997; Guzzetta, 1976; Therrien, 1979). Moreover, the data would be first analysed by correlational analysis in order to examine the relationships among the variables. Then, two linear regression analyses and one hierarchical regression analysis were employed in order to examine the predictive ability of the

independent variables (parentification and empathy). Specifically, the above approach was designed to investigate the following hypotheses:

1st Hypothesis: Parentification would significantly affect variations in counselling psychology trainees' empathy.

2nd Hypothesis: Parentification would significantly affect variations in counselling psychology trainees' boundary transgressions.

3rd Hypothesis: Empathy would significantly affect variations in counselling psychology trainees' boundary transgressions, over and above parentification.

Method

Participants

A total of 38 participants were recruited to take part in the questionnaire study. Participants were recruited from counselling psychology training courses in England. Overall, 70 questionnaires were sent out and 40 replies were collected (an initial response rate of 57%). Out of the 40 questionnaires, 2 were excluded from analyses due to incomplete response. The remaining 38 usable questionnaires represent a final response rate of 54 per cent. The sample was predominantly female (36 females, 2 males).

Materials

Parentification scale: Parentification questionnaire (PQ-A): is a 42 item self-report instrument measuring instrumental and expressive parentification during childhood and

adolescence (Sessions & Jurkovic, 1986). The PQ-A measures retrospectively, the subjective experience of caretaking responsibility between child and parents in the family of origin. Wolkin (1984) reported an overall mean of 21.10 (SD = 6.95) for the normative sample (N = 359 undergraduates). Sessions and Jurkovic (1986) state that the higher the score, the higher the degree of parentification. This scale has been found to have a Spearman-Brown split-half reliability of .85 and a Coefficient Alpha of .83 (Wolkin, 1984). The Test-retest reliability was found to be .86 over a two-week period (Burt, 1986). In addition, research has also reported convergent validity, proposing that scores on the PQ-A are related to predicted variables, such as lack of differentiation from the family of origin, choice of a caretaking profession, features of depression, and ambivalence about dependency needs (Burt, 1986; Goglia, 1992; Sessions & Jurkovic, 1986; Wolkin, 1984).

Empathy scale: The IRI is a 28-item, 5-point Likert scale that assesses four dimensions of empathy: 1) the 'Perspective-Taking', 2) the 'Fantasy', 3) the 'Empathic Concern' and 4) the 'Personal Distress' (Davis, 1980). Each of these four subscales is comprised of 7 items, and the possible range of scores for each subscale is 0 to 28. Previous studies (Bernstein & Davis, 1982; Carey, Fox, & Spraggins, 1988; Davis, 1983) have indicated good construct validity for the IRI's subscales, satisfactory internal reliabilities (range = .71 to .77) and test-retest reliabilities (range = .62 to .80) (Davis, 1980). In addition, Cronbach's alphas of .64, .76, .70, and .69 were computed for the Perspective-Taking, Fantasy, Empathic Concern, and Personal Distress subscales, respectively (Davis, 1980). Following literature recommendations, a single score of empathy has been derived from a simple sum of the EC, FS, and PT subscales (Pulos et al., 2004).

Boundaries scale: Epstein and Simon (1990) devised the Exploitation Index (EI) that informs therapists that they may be in danger of transgressing boundaries with a client. Exploitation Index as a self-assessment consists of 32 items that are divided into 7

subcategories: generalized boundary violations, eroticism, exhibitionism, dependency, power seeking, greed, and enabling. This tool was chosen because it measures both sexual and nonsexual predictors for boundary violations. A total EI score was calculated for each respondent by assigning a value of 0 for frequency responses of "never", 1 for "rarely", 2 for "sometimes" and 3 for "often". A total EI score of 0 corresponded to endorsing never on all 32 items. The maximum possible score of 96 would have been achieved by scoring 3 to every item. EI had a moderately high internal consistency; Cronbach's Alpha= .81 (Epstein, 1994).

Design

The current study employed a survey design using different questionnaires to examine the relationship between the variables. Parentification, empathy and boundary transgression as continuous variables were analysed using correlation and hierarchical regression analysis.

Correlation analysis was used to explore the relationships between parentification, empathy and boundary transgressions variables. Moreover, data were examined to ensure that assumptions for multivariate analysis were met. Liner regression analyses were employed to examine if parentification (predictor variable) can predict levels of empathy (criterion variable), as well as empathy (predictor variable) can predict boundary transgressions scores (criterion variable). Hierarchical analysis allows the researcher to organize data entry prior to analysis in a manner that reflects prescribed hypothetical ordering of predictor variables (Petrocelli, 2003).The hierarchical analysis was performed to test the hypothesis whether empathy (predictor variable) could account for variation in boundary violations scores (criterion variable), after controlling for the effect of the control-independent variable of parentification. The hierarchical order of the data was selected based on the chronological sequence of the variables, and the rational order of their occurrence.

One consideration in regards to the design of the current study was the sample size. The sample size is crucial for statistical power and generalisability of results. According to Hair et al, (2006) a minimum number of observations to independent variables cannot fall below a ratio of 5:1, with a preferred ratio at 15 or 20: 1, in order for the results to be generalised. The sample size for this study was 38 with a calculated observation to independent variable ratio of 18:1.

Procedure

The target population was limited to psychology trainees located through email invitations and a BPS advertisement. Recruitment information was sent to the BPS counselling psychology division for publication (see Appendix 2). Participants who indicated their willingness to participate received through post a stamped and self-addressed envelope with informed consent, information sheet, and the questionnaires (See Appendices 3, 4, 7, 8 and 9). Each participant was asked to indicate if statements in the Parentification Questionnaire, Exploitation Index, and Interpersonal Reactivity scales were accurate descriptions of their experiences. In terms of the privacy and confidentiality of participants, according to the BPS's guidelines the current research ensured that participants were not personally identifiable and data collected was anonymised by numbering questionnaires and deleting potentially identifying information. In terms of valid consent and in accordance with the Code of Ethics and Conduct, this study ensured that participants' consents were obtained freely after they received sufficient information, and even then, participants were able freely to withdraw their participation, until the completion of the data gathering phase.

Participants were thanked for their participation and were informed that an abstract of the results would be available upon request after the completion of the study, via email. After

the completion of the data collection, the questionnaires were gathered and further analysed statistically.

Results

The following analytic procedures were used to examine the data. First, descriptive statistics for all the variables were examined. Second, Pearson correlation coefficients were employed to investigate relations between variables of parentification, empathy and boundary transgression. Then, two linear regression analyses were used to examine the predictive power of parentification in which empathy served as a criterion variable, and the predictive power of empathy in which boundary transgression served as a criterion variable. Last, a hierarchical regression analysis was used to evaluate the common and unique aspects of parentification and empathy in explaining boundary transgressions.

Initial exploration of the data revealed an outlier in the dataset. The outlier was excluded from subsequent analyses. Although the distributions of parentification and empathy showed a slight skewness to the right, a Kolmogorov-Smirnov test showed that both variables were normally distributed (parentification, $D(37) = 0.11$, $p > .05$, and empathy, $D(37) = 0.13$, $p > .05$). On the other hand, there was a significant positive skewness in the distribution of the exploitation index ($D(37) = 0.15$, $p < .05$) (Field, 2005). The Log transformation was used to correct the positively skewed exploitation index scores (Field, 2005) and the transformed data was further explored and statistically analysed.

Table 1 presents descriptive statistics for PQ, IRI and transformed EI. The mean parentification score was 25.14 (SD= 7.91). A clinical cut-off has not been established, however, Jurkovic (1977) suggests that individuals' scores should be interpreted relative to their deviation from the mean of the sample from which the individuals' scores were drawn. This study used one standard deviation from the mean as the middle ground, while scores greater/less than 1 standard deviation represented the higher and lower band. Utilising this

suggestion, 19% of the current sample endorsed higher parentification scores, implying likely destructive form of parentification, while 14% gave lower scores, implying that these participants were not feeling parentified at all. However, very low scores may symbolise infantilisation (Jurkovic, 1997). In addition, 54% of the current sample had scored around the mean, which may imply an adaptive form of parentification. In other words, the current sample seems to indicate low levels of destructive parentification, meaning that most of the participants reported an adaptive form of parentification.

Table 1. Descriptive Statistics on Parentification, Empathy and Boundary Distortions

N=37	Mean	Std. Deviation
Parentification scores (PQ)	25.14	7.91
Empathy (IRI)	60.16	4.80
Log exploitation (EI)	.88	.26

The descriptive statistics of the IRI revealed that there was some variation between the current sample scores compared to normative data reported by Davis (1980). Breaking down the results, the trainees in the current study scored comparatively higher on the perspective taking and empathic concern subscale than did the participants from Davis's normative sample (see Table 2.). However, moderately lower scores were obtained by the current sample on the fantasy and personal distress scale compare with Davis's sample (see Table 2.). Overall, the current sample seemed to display higher levels of the positive aspects of empathy, such as understanding the perspective of others and the ability to focus on other people's distress. However, participants' scores were lower in displaying personal distress in tense interpersonal settings.

One explanation for these findings may lie in the suggestion that individuals who are drawn to the caregiving professions are gifted with increased levels of empathy (Barnett, 2007). On the other hand, the training program might have already focused on the trainees' development of interpersonal skills which may account for their elevated scores in empathy in comparison to normative samples among college students in Davis' study (1980), even before qualifying.

Table 2. IRI's score: current sample and normative data

	Sample scores		Normative Data	
	Mean	(SD)	Mean	(SD)
Perspective taking scale	21.30	(2.49)	17.96	(4.85)
Empathic concern scale	23.20	(2.90)	21.67	(3.83)
Fantasy scale	16.8	(3.30)	18.75	(5.17)
Distress scale	9.05	(2.33)	12.28	(5.01)

Moreover, the mean exploitation score was 8.06 (SD= 5.25) (log transformed: 0.88, SD= 0.26). However it would be important to present the descriptive statistics of each item in order to obtain a deeper understanding of the data. Closer inspection reveals that 92% of the current sample reported at least one "generalised boundary" and "eroticism" violation, 60% reported at least one "enabling" violation, 32% reported at least one "power seeking" violation, 24% reported at least one "exhibitionism" and "greediness" violation, whereas none of the participants reported any dependency violations. The above percentages revealed that the current sample had higher scores in categories of general boundary crossing, eroticism and enabling as compared to the other categories. However, as has already been

mentioned in the literature, these categories contained some items which are ambivalent with regard to their ethical and therapeutic nature. In addition, the entire sample in the current study obtained scores far below the suggested cut off point (i.e. 27) for high risk category, suggesting that as a whole, participants had low engagement with boundary transgressions.

Correlational analysis

As can be seen in Table 3, the results of Pearson Correlation analysis indicated that Parentification was significantly positively correlated with empathy ($r = 0.54$, $p < 0.001$), and the exploitation index ($r = 0.55$, $p < 0.001$) suggesting that the higher the scores of parentification the higher the scores of empathy, and exploitation index. Empathy, in turn, was statistically positively correlated with the exploitation index ($r = .55$, $p < 0.001$), hence the higher the scores of empathy the higher the exploitation index scores. These reported correlation coefficients constitute a moderate to large size of effect (Cohen, 1988, 1992) indicating that as the reported parentification increases, the feelings of empathy and the reported boundary transgressions are likely to increase too. In addition, the test also showed that the higher the levels of empathy, the more likely the engagement with boundary transgressions, in trainees.

Table 3. Correlation coefficients among parentification, empathy and boundary transgressions by Pearson's correlational test

	parentification	empathy	exploitation
parentification	1		
empathy	.539**	1	
exploitation	.547**	.547**	1

**. Correlation is significant at the 0.01 level (2-tailed).

Regression analysis: parentification and empathy

Linear regression analysis was carried out to determine whether parentification (predictor variable) could significantly predict empathy (criterion variable). The value of R2 is 0.29 (adjusted R2= 0.27), indicating that parentification could account for 29% of variance in trainees' empathy ($F=14.31$, $p<0.001$). In addition, the scatterplot of the relationship (Figure. 1) between parentification and empathy illustrates a more or less linear positive relationship between these two variables. The standardised β value for parentification is .54 which indicates that as parentification increases by one standard deviation (7.91), boundary distortions increase by .54 standard deviations; $t(35)=3.84$, $p<0.001$. The equation is $Y= 51.95+ (0.33X)$ where X is an individual's parentification score and Y is the best prediction of their score on empathy. The 95% confidence interval for the slope of the regression line is 0.15 to 0.50, indicating that the current model is likely to be representative of the true population values (Field, 2005).

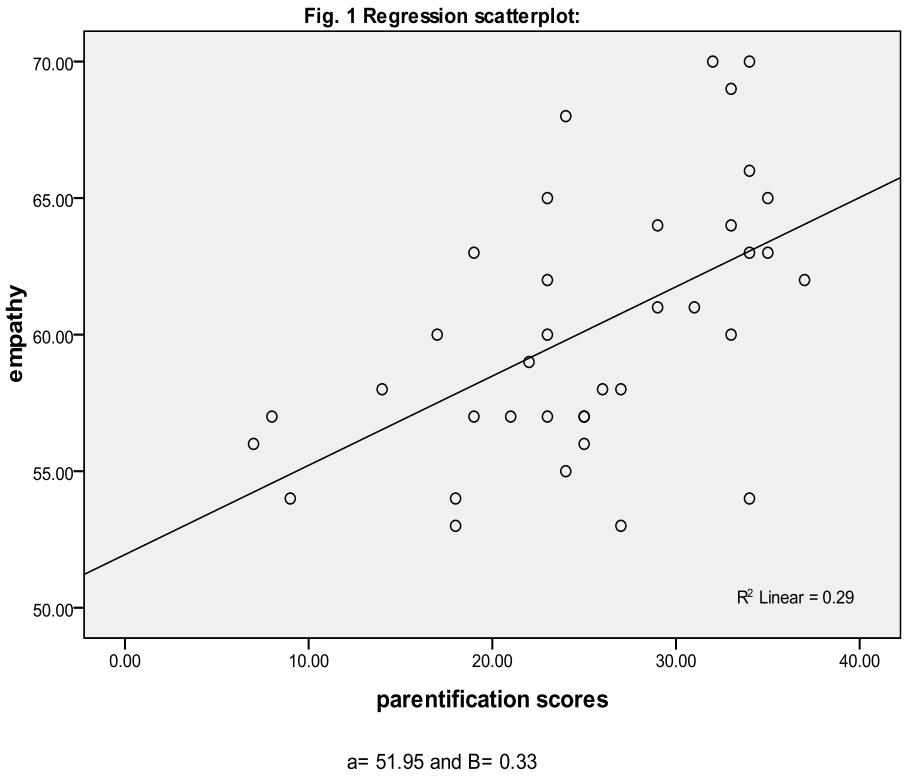

Figure 1. Scatterplot between parentification and empathy

Regression analysis: Empathy and boundary violations

Linear regression analysis was carried out to determine whether empathy could significantly predict boundary violations. The value of R2 is found to be 0.30 (adjusted R2 = 0.30), so empathy could account for 30% of the variance in boundary violations ($F=14.93$, $p<.001$). Therefore, the regression model overall predicts boundary violations significantly well. In addition, the scatterplot of the relationship (Fig. 2) between empathy and boundary violations suggests a linear positive relationship between two variables. The standardised β value for empathy is .55 which indicates that as empathy increases by one standard deviation (4.80) boundary distortions increase by .55 standard deviations; $t(35)=3.87$, $p<.001$. The equation is Y= -0.93+ (0.03X) where X is an individual's score on empathy and Y is the best prediction of their score on boundary violations. The 95% confidence interval for the slope of the regression line is 0.01 to 0.05, indicating that the estimates for the current model are likely to be representative of the true population (Field, 2005).

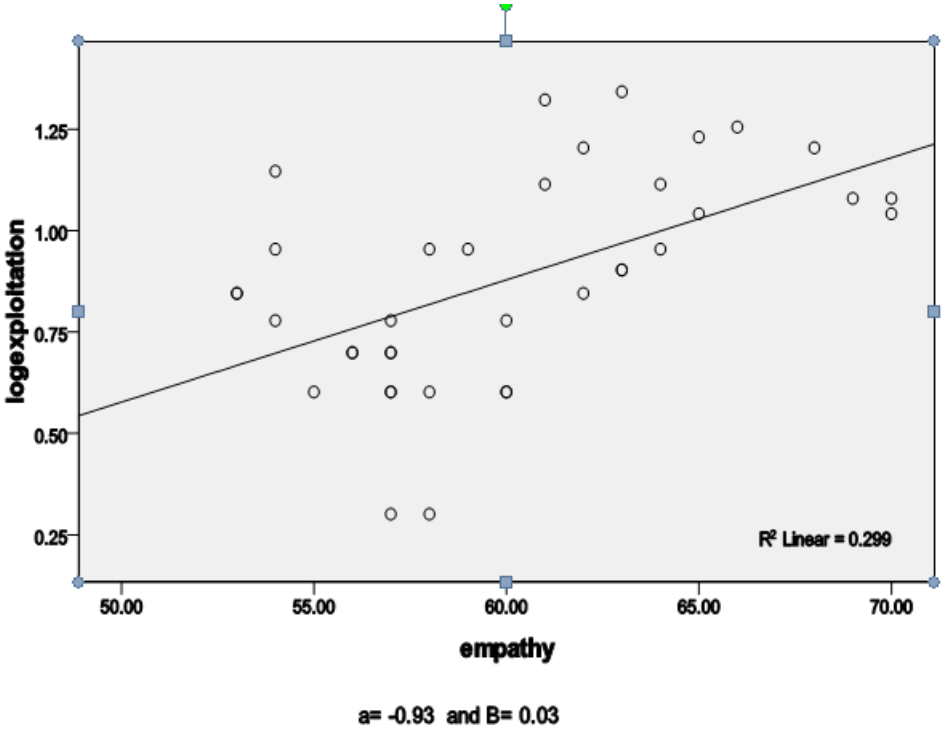

Figure 2. Scatterplot between empathy and boundary transgression.

Hierarchical Regression Analysis

First, multicollinearity and normality were both checked in order to ensure the validity of the regression analysis. In this study, the correlation between independent variables (parentification and empathy) was 0.54, less than 0.6 which could indicate multicollinearity (Field, 2005). In addition, the tolerance value was checked and found to be above 0.1 suggesting small possibility of multicollinearity and the VIF value was less than 10 indicating no multicollinearity. In addition, the variance proportions varied between 0 and 1, and for each predictor variance was distributed across different dimensions (parentification had 78% of variance on dimension 2 and empathy had 99% on dimension 3) verifying the previous suggestion of no multicollinearity; therefore, all variables were retained.

The assumptions of normality, linearity, homoscedasticity, independence of residuals and outliers were checked using the scatter plot of the residuals, the histogram, and the normal probability plot. In this study, the normal probability plot showed points lying not very distant from the diagonal line suggesting no major deviations from normality. Normality was also checked by assessing the histogram, for which the boundaries distortion variable appeared to be roughly normal although there was a slight deficiency of residuals on zero. In addition, the standardised residuals in the scatterplot had a slightly funnel shape distribution, in which the scores spread a little across the graph. However, there was no clear or systematic pattern to the residuals, indicating that the assumptions of linearity and homoscedasticity have been met.

Independence of errors was checked through looking at the Durbin-Watson coefficient value. As Field (2005) suggests a value of less than 1 or greater than 3 is cause for concern, where this assumption is likely to be met if the Durbin-Watson statistic is close to 2 (see Field, 2005:190). In this study the value was 1.807, indicating that this assumption is

likely to be met. On the whole, this model appeared, in most senses, to be both accurate for the sample and generalisable to the population, as the assumptions had been met.

Following the analysis, the predictor 'parentification' entered into the analysis first (Model 1), followed by the empathy variable (Model 2). As has already been discussed above (design section), the order of the data was selected based on the chronological sequence of the variables, and the rational order of their occurrence. Overall, the results indicated that parentification and empathy made the strongest unique contribution to explaining boundaries distortion (see Table 4.). For the first model the R2 was 0.30 (adjusted R2= 0.28), which means that parentification accounted for 30% of the variation in the exploitation index. This result verified the second hypothesis of the study, which states that parentification would significantly predict variations in boundary transgression ($F=14.95$, $p<.001$). Therefore, model 1 predicted boundary violations significantly well. The equation is $Y' = 0.42 + (0.02X)$ where X is an individual's parentification score and Y' is the best prediction of their exploitation index score. The 95% confidence interval for the slope of the regression line is 0.01 to 0.03, indicating that the estimates for the current model are likely to be representative of the true population (Field, 2005).

Next, the addition of the second block (empathy) results in an increase in R2 of 0.09 (adjusted R2= 0.35) that is, in excess of an additional 9% of the variance in exploitation index is accounted for and this increase is highly significant (F change $(1, 34) = 4.98$, $p< .05$), bringing the total proportion of explained variance to .35. In addition, for the second model F ratio is 10.81 which is also highly significant ($F(2, 34) = 10.81$, $p < .001$). Overall, the above results show that both parentification and empathy contributed to the overall relationships with the exploitation index for around 35% of the variance, and that empathy accounts for 9% of the variance in boundary distortions once parentification is controlled for.

Table 4. Hierarchical regression analysis.

Model		B	Std. Error	Beta	T	Sig
1	(Constant)	.423	.124		3.401	.002
	parentification scores	.018	.005	.547	3.866	.000
2	(Constant)	-.593	.471		-1.260	.216
	Parentification scores	.012	.005	.356	2.235	.032
	empathy	.020	.355	.355	2.231	.032

Note R2= .29 for step 1; ΔR2 = .09 for step 2 (ps < .05). * p< .05

Moreover, the standardised β value for parentification is .356, which indicates that as parentification increases by one standard deviation (7.91), boundary distortions increase by .356 standard deviations, and so this constitutes a change of 0.094. This interpretation is true as long as the effect of empathy is held constant. Similarly, the standardised β value for empathy is .355, which indicates that as empathy increases by one standard deviation (4.798), boundary distortions increase by .355 standard deviations, and so this constitutes a change of 0.093. This interpretation is true as long as the effect of parentification is held constant. Additionally, the standardised values of parentification and empathy are almost identical indicating that both variables have a comparable degree of importance in the model (.356 and .355 respectively), which concurs with the magnitude of their t-statistics which for the model 2 are $t(34) = 2.24$, $p<.05$, for parentification and $t(34) = 2.23$, $p<.05$ for empathy. Still, the R2 value (r = .39) for this model reveals a medium effect size. Thus, we conclude that the best fitting model for predicting boundary distortions is a linear combination of the parentification and empathy levels.

Discussion

The aim of the quantitative research was to examine the relationships among parentification, empathy and professional boundaries transgressions. The first hypothesis in regard to whether parentification would significantly predict scores in empathy was verified, in that parentification scores accounted for the 29% of the variance in empathy. The current finding is consistent with previous studies suggesting that parentification is associated with higher levels of emotional understanding (Fitzgerald, 2005). In addition, the concept of wounded healer that emphasised the importance of personal experiences, as a means to understand and helping others, was also supported to some extent.

Moreover, this finding supports the idea that early attunement to the needs of caregivers may enhance empathic capacity in later life (Jurkovic, 1997). In other words, early demands for enhanced emotional understanding may develop further the individual's level of empathy. However, further studies are needed in order to eliminate other possible variables that may play a role in empathic ability such as child characteristics.

Further, careful consideration should be given to the way in which the above positive relationship may be interpreted with regard to therapeutic effectiveness. On the surface, the current result supports that very high degrees of parentified experience will predict very high levels of empathy, meaning that some highly parentified therapists might display higher empathic skills that might be beneficial to their interpersonal therapeutic skill. This view is in agreement with theorists' notion that counsellors' ability to deal with early family distress may contribute to their later professional effectiveness (Wolgien & Coady, 1997; Watts et al., 1995). However, other studies have supported the view that extreme levels of empathy may be associated with low emotional separation from clients, leading to emotional enmeshment and boundary distortions, which will probably compromise the overall competence of the practitioner (Concoran, 1983; Schieman & Turner, 2001). This leads us to the conclusion that

moderate levels of parentification which do not correspond to extreme scores of empathy may better account for the effectiveness of parentified therapists. In contrast, extreme scores of parentification even though they correspond to extreme scores of empathy, may overall compromise therapeutic effectiveness. This suggestion is consistent with Hooper et al. (2011) emphasising the adaptive nature of parentification at moderate levels. Still, further research is needed in order to examine further the therapeutic utility of the above relationship.

In relation to the second hypothesis, the current study found that parentification accounted for a significant proportion of the variance of boundary transgression scores. Parentification scores alone significantly predicted 30% of the variance in boundary transgression scores. This result lends support to the idea that parentification as a relational pattern may be internalised and transferred to other relationships, even to therapeutic ones. However, more research is needed in order to take into account alternative variables that may explain the above relationship, such as low emotional regulation or self-other differentiation.

Moreover, the interpretation of this relationship, in terms of therapeutic utility, needs to be treated with caution. The above finding supports that higher scores of parentification in some may predict increased boundary transgressions. Following the slippery slope argument, increased boundary transgressions may lead to malpractice. Therefore, it can be suggested that the destructive impact of parentification is more to do with those with more extreme scores, as they may be associated with elevated risk for boundary transgressions. This finding was consistent with family systems and object relation theories supporting the claim that parentification may lead to the development of maladaptive schemas of enmeshed relationships in some individuals, which tend to transfer to other relationships (Byng-Hall, 2008; Bourassa, 2010).

On the other hand, moderate levels of parentification may predict minor boundary transgressions, which based on the opponent view of the slippery slope argument, may imply

a better practice in that appropriate boundary crossing may enhance therapeutic effectiveness (Cornell, 1997; Dunne et al., 1982; Lambert, 1991; Lazarus & Zur, 2002; Norcross & Goldfried, 1992). Thus, the current results echo clinical observations of adaptive parentified therapists, in their possible increased ability to go beyond conventional practices and to accommodate therapeutic boundaries according to the complexity and uniqueness of each client (Jurkovic, 1997). However, taking into consideration the slippery slope argument, even minor boundary transgression may lead to boundary violation; therefore the current interpretation should be treated with caution.

The third hypothesis as to whether empathy would account for the variations in professional boundary transgression, after controlling for the effect of the control-independent variable of parentification, was also verified in the study. Inserting empathy to the model, with parentification being controlled for, added an additional 9% to the explained variance, leaving 39% of the variance in professional boundary transgression being predicted. Trainees' empathy was predictive of professional boundary transgression, beyond the shared variance of parentification. The current finding is consistent with Epstein's (1994) theoretical framework in that the higher the level of attunement with the clients' feelings, the looser the boundaries are in a therapeutic relationship, over and beyond the therapist's early history. Therefore, empathy as well as the common variance with parentification has its unique relationship with boundary transgression.

Interpreting this result, higher scores of empathy would predict increased boundary transgressions that according to the slippery slope argument could lead to a risk of malpractice. However, taking into account the opponents of the slippery slope argument, low degree of boundary transgressions may imply boundary flexibility, therefore, the above finding suggests malpractice only in extreme levels of empathy. Still, as the scores of boundary transgression in the current study were far below the risk limit, we can infer that

only extreme scores of empathy can predict important boundary distortions which can account for malpractice, whereas less extreme scores may suggest a boundary flexibility, which in turn is associated with therapeutic effectiveness (Lazarus & Zur, 2002). However, further research is needed to verify current results and clarify more fully the therapeutic impact of these relationships.

Overall, the current findings are in agreement with Hooper et al. (2011) proposing that low levels of parentification may be beneficial, whereas extreme levels of parentification may account for the destructive reported impact. In other words, moderate occurrence of parentification may entail the appropriate level of challenging that promotes further development. In contrast, high occurrence of parentification goes beyond appropriate challenging to an overburden that may compromise further development. The current findings of moderate predicative relationship between parentification, empathy and boundary transgression, suggest possible boundary flexibility, and beneficial levels of empathy.

Research limitation

Several limitations to this study must be considered. First, the relatively small sample size of this study might limit the generalisability of the results. Second, the analyses were based on self-report data. Participants could have answered in ways they perceived to be socially desirable, especially in the exploitation index, which could potentially reveal inappropriate professional practice. Consequently, the data may be affected by a response bias even though the design of the study strived to minimise the response bias by not collecting the participants' details with anonymous administration.

Moreover, the current sample mainly consisted of female respondents, whereas research with a balance of genders would be useful to confirm any gender differences. Finally, the relationships being examined were correlational and this research could not

control many extraneous variables, which might have confounded the results, such as self-other differentiation, and emotional separation.

Another possible disadvantage of the current study was the retrospective nature of the self-report questionnaire of parentification, which may influence the result due to memory distortions of the participants. In addition, some considerations in relation to measurement can also be a source of limitations. For instance, the parentification questionnaire does not specify the quality and the length of parentifying experience which could discriminate among healthy and unhealthy parentification. Furthermore, the Exploitation Index used to measure boundary transgressions, can take into account but not distinguish between boundary crossing and boundary violations, which makes it difficult to draw conclusions about malpractice. As has already been mentioned in the literature, boundary crossing may have a beneficial impact in the therapeutic process if it is in accordance with clients' needs (Gottlieb & Younggren, 2009; Lazarus & Zur, 2002; Norcross & Goldfried, 1992). Taking the above into consideration, further research is needed to address the current limitations, and explore further the current findings.

Clinical implications

The current study aimed to investigate the role of parentification in therapeutic practice which entails important implications for clinical training and practice. In training, understanding the impact of parentification in professional practice can increase trainees' and supervisors' awareness for possible talents and vulnerabilities in the therapists' interpersonal skills. Clinical supervision may play an important role in utilising parentified therapists' capacity to be empathic and guard against empathic over-arousal by monitoring the balance between empathy and maintaining boundaries. In the same way, supervision can closely attend to minor boundary transgressions in order to evaluate their therapeutic effectiveness,

minimising the risk for potential boundary violations. It is important that parentified therapists get enough holding and containment to understand their history of parentification and attune to their own wounds. In this way parentified therapists will be able to use this 'inner healer' wisely to benefit their therapeutic work.

Moreover, the increased awareness of the parentified self and other in a helping relationship may prevent the overuse of the caretaking role which leads to enmeshed therapeutic relationships. In order to promote ethical practice, training programmes should be proactive in educating trainees for the destructive impact of boundary violations, as well as for the potential danger of repetitive boundary crossing. Equally important, is the need for personal therapy and personal development which will address in a more therapeutic way unresolved issues and unmet needs. As has already been mentioned, it is very important that the therapists undergo their own personal healing experience in order to promote healing in others. In essence, personal therapy, training and supervision may prepare parentified trainees for the challenges they may face due to their inexperience by expanding their potentials and managing their difficulties.

The results of this current study suggest of possible links between parentification, empathy and boundary transgression. However, the extent to which experience of parentification may enhance or hinder therapeutic effectiveness is still in question. Further research is needed to verify the current suggestions. For this purpose, a qualitative exploration of trainees' experience of parentification might be able to shed more light into the nature of the observed relationship revealed by the regression analyses.

The wounded healer: The experiences of parentified therapists in professional practice

Introduction

The first part of the project has concentrated on measuring trainees' levels of parentification, empathy and boundary transgressions in order to examine the relationships among them. The findings supported a significant positive relationship among them. Specifically, parentification could significantly predict empathy as well as boundary transgression in some counselling psychology trainees. In addition, empathy could significantly predict boundary transgressions after controlling for the effect of parentification. The current findings of moderate predictive relationship between parentification, empathy and boundary transgression, suggest possible boundary flexibility, and beneficial levels of empathy. Therefore, the suggestion stemming from the first part of the research was that the destructive impact of parentification such as elevated risk for boundary transgressions and emotional enmeshment may be more to do with those with extremes scores.

However, further research is needed to fully examine the above suggestion, as the quantitative study could not fully account for qualitative differences among variables to further verify their therapeutic utility. In other words, high levels of empathy, as well as increased incidence of boundary transgressions, may not necessarily destructively impact on professional practice. In the light of this, a qualitative study was employed to provide an in depth understanding of the nature of empathy and boundary keeping that parentified trainees may experience in their practice.

Qualitative studies have already been employed to study the early experiences of therapists under the theoretical umbrella of the wounded healer (Cain, 2008; Barnett, 2007). Biographical narratives and case studies have described therapy in terms of a wounded healer, where therapists use their experience of personal healing to inform their work. One direction of inquiry in qualitative research was the understanding of how early experiences

can motivate and aspire individuals to choose a psychologist's career. For instance, Racusin and colleagues (1981) looked at the impact of the therapist's family dynamics on career choice and they found that three-quarters of the therapists reported having been the family caretaker, assuming either parenting or counselling roles. Similarly, Fussell and Bonney (1990) compared self-reported childhood experiences of 42 psychotherapists with a comparable group of 38 physicists and he found a higher number of instances of parental absences and parent –child role reversal in the life of psychotherapists. More recently, Barnett (2007) identified early loss and narcissistic needs as the two main themes in the early years of nine experienced psychotherapists. According to this research (2007) early familial dynamics may cultivate an inner need to enter into a helping profession.

Apart from the prevalence of difficult early experiences and its relative influence on the choice of profession, other qualitative studies have analysed whether early experiences were related to therapeutic skills. For instance, Watts, Trusty, Canada, and Harvill (1995) investigated the relationship between perceived early family influence and counsellor effectiveness in master's level practicum students. Their results indicated that counsellor trainees who were rated as more effective tended to perceive their parents' relationship and parent– child interactions more negatively than did less effective counsellor trainees. On the other hand, Jennings and Scovholt (1999) interviewed 10 master therapists who described that their increased ability to relate to clients may have originated in the skills developed in their families of origin, such as listening, observing, and caring for the welfare of others.

Yet further studies have focused on understanding the countertransference of wounded therapists, as one main concern is that through countertransference the wounded therapists will displace unresolved feelings onto the clients (Cain, 2000). Countertransference can take an affective form (anger, sadness, or anxiety), a cognitive form (errors in perception) and behavioural form (avoidance, distancing, over-identification, or other forms of acting

out) (Cain, 2000; Hayes & Gelso, 2001). Most of the research supports that countertransference has its origins in the therapist's childhood years mainly stemming from unresolved conflicts from the therapist's family of origin, as well as parenting roles and responsibilities (Hayes & Gelso, 2001, Gelso, Fassinger, Latts, & Gomez, 1995).

In the light of this, Cain (2000) investigated the countertransference issues in psychotherapists with histories of emotional struggle and mental illness. The main common countertransference experiences are concerns about hospitalisation of the client, comparisons of therapist with clients and over-identification with clients. In addition, practitioners reported that their countertransference may sometimes have negatively impacted on clients by their different agendas and fluctuations of the therapist's well-being. In contrast to the negative impact, participants confirmed that overall their early experiences had inspired and informed their work. Specifically, participants referred to increased hope, empathy and trust between therapist and client, increased tolerance of a variety of clients' emotions and behaviours, as well as the incorporation of models of empowerment and recovery. Participants reported that their histories had inspired and informed their clinical work, greatly increasing their empathy with patients as well as building their own trust and faith in recovery (Cain, 2000). In essence, Cain's study emphasised that although therapists with histories of emotional struggle may face some difficulties with regard to maintaining a therapeutic neutrality and optimal emotional distance with clients, overall their early history increases their empathic skills and therapeutic flexibility across different clients.

Although participants in the above studies have reported parentified experiences, there have been very few qualitative studies performed to date that have focused specifically on the impact that parentification brings into therapeutic practice, especially in terms of empathy and boundaries. A notable exception is DiCaccavo's (2006) case study in which she raised a concern about parentified therapists working with parentified clients. She proposes

that some parentified therapists may be at risk of inserting their own unarticulated feelings into clients, may have difficulties in maintaining a high level of containment, or may show signs of compulsive care-giving.

It appears to be agreed that difficult early experiences motivate and equip individuals to follow helping professions (Barnett, 2007; Burton, 1972; DiCaccavo, 2002, 2006; Fussell & Bonney, 1990; Halewood & Tribe, 2003). Despite this, the research on how specific early experiences may impact on the therapeutic process is relatively small (Fussell & Bonney, 1990; Hayes, 2002; Sussman, 1992). In an effort to shed some light on the above inquiry and following the findings of the quantitative study, the second part of the research focused on understanding how parentification may impact on therapeutic practice.

A qualitative design was employed in order to clarify and provide a deeper understanding of the way parentified experience might impact on therapeutic practice, especially with regard to empathy and boundary transgressions. This qualitative study aimed to provide a richer description of the impact that parentification may have on therapists' practice. Although the quantitative study provided a general description of the phenomenon, the qualitative approach used in this study aimed to delve into complex processes and unravel the multifaceted nature of parentification.

In addition, the quantitative methodology illustrated the associations connected with early parentification and the therapist's current levels of empathy and boundary transgressions but lacked the context and meaning that qualitative methodology could offer. Consequently, the use of a different approach was aimed to cancel out the 'method effect' and to increase confidence in the findings. Taking into account the variations in parentified experiences, and the relative impact on practice, a qualitative study was used in order to place importance on all observations no matter how deviant from the 'norm' they are. Understanding parentified psychology trainees' experiences will not only provide insight into

the difficulties and potentialities that this particular group may deal with; it will also provide important insights into issues relevant to the facilitation of the counselling process, of interest to supervisors and training providers.

Moreover, in interviewing specifically psychology trainees, the intention was to gain insight into how parentification may impact on their therapeutic work without being moulded by experience and age. In specific, boundary violations seem to increase with age and years of experience. In support of this view, Epstein, Simon, and Kay (1992) report that psychiatrists in the age group of 45-52 years present more exploitative behaviours than psychiatrists in the age group of 27-36 years. Also Rodolfa et al (1994) propose that psychologists over 44 years tend to display higher incidence of sexual boundary violations than younger psychologists. In addition, therapists with more years of experience tend to display more boundary violations in comparison with less experienced therapists (Lamb et al., 1994, Borys & Pope, 1989). Stake and Oliver (1991) reported that less experienced psychologists were more likely to define sexually suggestive behaviour as misconduct in comparison with more experienced psychologists. A possible reason for the above findings is that ethical judgement may decline with age and experience (Borys & Pope, 1989; Epstein et al., 1992). Taking these factors into consideration, the current study recruited trainee psychologists in order to reduce age and experience as confounding variables. The selection of trainees as participants aimed to focus on the more direct form of struggles and abilities that parentification brings to the profession, without being minimised or enhanced by therapeutic experience.

Methods

Participants

For the purpose of the current study, 4 participants were recruited through a second personal invitation to local universities. A sample of 4 psychology trainees took part in the study. The sample included four women, who had been working as trainees for 2 years. Most participants were white, apart from one Asian. The age of the participants ranged from between 27 - 32 years and all participants were actively engaged in seeing clients at the time the interviews took place.

Design

In depth interviews were obtained for a thematic analysis (TA) (Braun & Clarke, 2006) to explore in more depth counselling trainees' awareness and experience of the likely impact of parentification on their work, especially on the way they set boundaries and experience empathy. Thematic analysis is a method for identifying and analysing patterns within data. Thematic analysis was preferred to grounded theory as it is used to describe and analyse the experience of parentified therapists with empathy and boundaries, instead of building a theory that explains the findings within the data. In addition, thematic analysis was preferred to interpretative thematic analysis as the purpose of the current research was to explore and objectively report the experience of participants. Thematic analysis is perceived as an essentialist or realist method, which reports experiences, meanings and the reality of participants (Braun & Clarke, 2006).

The current analysis was based on inductive analysis or data driven. This approach refers to analysis and coding of data without trying to adapt it to a pre-existing knowledge. However, taking into consideration that the researcher will always be affected by their pre-existing knowledge or their pre-assumptions, a pure data driven process seems difficult. In

other words, the researcher's pre-existing knowledge may even influence the attention given to different elements of participants' interviews. Taking into consideration the obtained knowledge from the quantitative study, for this study to be free from pre-assumption could be especially difficult. However, as the quantitative study did not offer a clear direction in relation to the therapeutic utility of parentified experience, a theory-driven approach could run the risk leaving out unattended yet important information, which had not been captured by the questionnaire study. Even though some themes may match with the pre-existing theory, a data-driven approach would offer the possibility to identify more themes, beyond the ones that may otherwise be identified by the theory alone. Therefore, the data-driven approach was selected as a way to add information and shed more light on the impact of parentification, instead of providing support for the first study.

Further, in order to account for researcher's possible bias, the data analysis was concluded after being evaluated by an independent researcher. For this purpose, the results were evaluated by an independent researcher from the counselling field and by the research supervisor, in order to carry out an appraisal of the content and structure of the analysis. The feedback from the independent assessments improved the choice, the structure, the connection and the coherence of the themes and subthemes, as well as their interpretation. The evaluation process enhanced the objectivity and improved the valid representation and interpretation of the themes.

Procedure

Following the questionnaire study, semi-structured interviews were carried out with 4 psychology trainees, who identified themselves as being parentified, to explore further the extent to which some trainees' experience of their own parentification might affect boundaries and empathy in their practice. The research questions aimed to collect more in

depth information across participants and to provide a framework to gather detailed data of the personal experiences of parentified therapists.

For the qualitative part of this study, the interview schedule was pilot tested by the researcher on counselling trainees, before the main research, in order to improve the utility of the research questions. The pilot study helped to ensure that the wording and the sequence of the questions would elicit responses relevant to the research topic. In addition, the pilot study helped to identify ambiguities and difficult questions, as well as to record the time taken to complete the interview and decide whether it is reasonable. Additionally, the process of the pilot study gave some experience and confidence in conducting an interview schedule.

Four participants had identified themselves to me as parentified individuals prior to commencing the research and were subsequently invited to take part in this research. Each person was approached individually and provided with both verbal and written information about this study and what their involvement would entail. The main inclusion criteria for the study were to be presently working as psychology trainees and to aware that they have experienced a parentified role in their family of origin. The awareness of participants' role reversal in their family of origin was very important as the objective of the study was to describe in depth their experience and its influence on the professional practice. Therefore, participants were asked to identify themselves as being parentified in order to participate in the interview. Consent forms and information sheets were sent out to potential participants and their consents were obtained before the interviews commenced (See Appendix 5, 6). Each interview took place in an agreed and secure setting, such as a quiet room in a local library. In terms of protecting participants' anonymity they were asked to choose a pseudonym to use during the interview, which was used during the transcription and data analysis. Participants were informed once more of their right to withdraw at any time without any implications, as well as about any potential risk, such as recalling unpleasant experiences.

In addition, the researcher used her counselling experience to approach with sensitivity and respect the participants.

A set of questions was employed in order to guide the interview that lasted approximately 20-40 minutes each. The interview schedule (Appendix 10) started with more generalised questions in order to ease the participants into talking about the subject, followed by more specific questions that focused the discussion on issues related to parentification and therapeutic practice. After the completion of the interview, the participants were thanked for their participation and informed as to how to obtain further information about the study upon its completion.

Overall, it was made clear to participants that they could withdraw from the study at any time, without any implications and that confidentiality and anonymity would be ensured throughout. The participants' interviews were audio recorded and later transcribed. However, any identification was removed from transcripts. After the completion of the study, the data would be protected by keeping it in locked cabinets and would be kept secure for five years, and after that it would be destroyed. Following data collection, thematic analysis (TA) was used for the analysis of the interview data.

Data analysis

The first step of data analysis was the careful and repeated reading of the transcripts in order for the researcher to increase familiarity with the data and get an initial sense of the content. In the second step, elements of the data that were related to the topic of interest were identified and coded in a systematic way in all four interviews, in order to generate initial codes. Codes are important features of the data which can later be clustered together in order to form the basis of themes (Boyatzis, 1998). Following this, the codes were evaluated and grouped together according to their shared meaning in order to form themes. While a higher

frequency of themes across data and participants signifies its importance, nonetheless, isolated themes which seem to offer a significant meaning are also considered important (Braun & Clarke, 2006).

Moreover, the initial themes were examined based on the criteria of internal homogeneity and external heterogeneity (Patton, 1990). Internal homogeneity, as a measure of cohesiveness, concerns the extent to which each subtheme or code is clustered together meaningfully and is well integrated into a theme. In addition, external heterogeneity refers to the extent to which differences between themes are distinct and clear. After careful examination of the themes, they are further redefined and reported in the final report. The report of the themes went beyond their description towards an analytic frame which could unfold an argument in relation to the research question.

The final stage of the research approach was assessing the validity of the analysis. Even though the researcher's effort to maintain objectivity and an unbiased stance from pre-existing knowledge by being reflective throughout the analysis enhanced the validity of the study, it was additionally verified by an independent assessment, as mentioned earlier.

Results and Discussion

The purpose of this study was to provide an understanding on how trainees' early role in the family of origin influenced their professional practice. Three domains were discussed: the experience of parentification, the impact of early role on professional practice and professional and personal development as a protective factor. The first domain was manifested in 4 themes: 1) conditions of parentification 2) type of parentification 3) the ascribed meaning of parentification 4) the direct impact upon the individual. The second domain consisted of 6 themes: 1) choice of profession 2) choice of therapeutic approach 3) enhanced empathy becomes central to the identity 4) boundary flexibility 5) enmeshed

therapist-client relationship 6) creativity. The third domain was analysed by three themes: 1) increased awareness of the tendency to transfer early familial roles in therapeutic relationships, 2) increased attention to self-care and 3) increased self-other differentiation.

Domain 1: The experience of parentification

Four themes were highlighted in the first part of the interview that explored the trainees' early role in their family of origin; 1) conditions of parentification 2) type of parentification 3) the ascribed meaning of parentification and 4) the direct impact upon the individual.

Theme 1: Conditions of parentification

Conditions of parentification refer to the specific familial circumstances in which parentification took place. Conditions of parentification were divided into 2 subthemes: familial circumstances and child characteristics. Three of the participants described the familial circumstances under which parentification took place, namely: maternal depression (P1: my mom had a tendency to be depressed), divorce (P1: parents divorced when I was young, P4: my parents were divorced, and my mom was working many hours) and large family (P3: I came from a big family so there was always so much stuff to do).

The subtheme of child characteristics was discussed by gender expectations and personality characteristics. Participant 4 referred to the idea of gender expectations by describing how being a young female child determined her prescribed role in the family (e.g. P4:" there was an expectation that as a female I learn about taking care of the house…"). In addition, one participant referred to personal traits which despite being the younger sibling, put her in a parentified role, such as maturity and responsibility (P3: "even though I was the younger one, I was always more responsible and mature").

This theme emphasised that familial circumstances may challenge parental resources and increase the need for the child to serve as a primary support unit. This theme is consistent with other findings reporting that parentification is more prominent in families with the absence of one parent through death or divorce, with the inability of a parent due to mental illness, substance abuse, family conflicts or intrusive parenting styles (Aldridge & Becker, 2003; Burnett et al., 2006; Goglia, et al., 1992; Jurkovic & Sroufe, 1987).

With regard to child characteristics, past research suggestions that older children are at higher risk of acquiring a caregiver role (East & Weisner, 2009; McMahon & Luthar, 2007) were not supported by the current findings, as most participants were the younger ones in the family. However, the current finding is in line with other studies supporting that child's intrinsic characteristics, such as competence, and level of maturity, may override birth order and increase the risk of younger children being drawn into care giving roles (Jurkovic, 1997). Indeed, this study supported that the child's personality traits, such as maturity and sense of responsibility, may enhance the probability of the individuals being drawn into a parentified role, independent of their birth order.

Moreover, only one participant stated that her familial gender expectations put her at a higher risk of instrumental parentification. However, as she was the only one coming from an Asian cultural background, it is not yet clear whether females are expected to acquire a care giving role in traditional families, increasing their risk for parentification (Burnett, et al., 2006; Mayseless & Scharf, 2009). Furthermore, other studies did not find gender differences in parentification (Castro et al., 2004; Johnston, 1990). Due to the small sample of the current study, further research is needed to clarify the existence of gender differences in parentification.

Theme 2: Type of parentification

The second theme identified as 'the type of parentification', was further separated into 2 subthemes: the type of the role and its duration. With regard to the type of early role, participants 1and 2 referred to emotional support, whereas participants 3 and 4 described both emotional and instrumental support. Emotional supporting role was described as:

P1:"…to be the clown, to make jokes, so I could see a smile on her face…" (L8-L9)

P2: "the peacemaker…the one keeping the peace, sorting out arguments" (L235-237)

P3: "I became the responsible one…the caretaker", "the agony aunt for everyone" (L384-L390)

P4: "a parent and a friend to my mom…to emotionally support my mom and I were the one who always compromised in order to retain the peace in the house" (L781-L784)

On the other hand, instrumental support was described as:

P3: "…a lot of chores to do…I did a lot of babysitting, cooking, cleaning, tidying up…" (L376-L377)

P4: "…I learned very young to cook and to support my mom…" (L782-L783)

With regard to the length of the role, participants 1 and 2 described a temporal duration of their role, signified by the words "at times", whereas participant 3 and 4 described a permanent duration of their role using the word "always".

In this theme, trainees' descriptions of emotional support emphasised their efforts to enhance the emotional well-being of their parents or siblings by different means, such as providing amusement, listening, resolving conflicts and offering advice. In addition, instrumental support focused more on promoting the physical well-being of the family by providing household support. These roles reflect well the process of parentification where the child acquires some parental responsibilities, and eventually becomes the parent of the parent.

Another critical distinction of this process is its duration varying from short term to long term. The type and duration of the role are among the factors that may differentiate the adaptive from destructive impact of parentification (Jurkovic, 1977). In support to this and as it will be presented in the following themes, participants 3 and 4 who reported long term emotional and instrumental parentification perceived their experience as more destructive and discussed extensively the relative impact that they experienced. In contrast, participants 1and 2 who reported a short term emotional parentified experience did not articulate any destructive impact. This echoes research findings that short term parental reliance on the child's resources may be perceived as adaptive and may enhance the child's development, whereas in long term parental alliance the role reversal becomes a typical relational pattern which can be detrimental to the child (Jurkovic, 1997).

Theme 3: The ascribed meaning to their care-giving behaviour

Limited familial resources called for parentified trainees to play an active role in the family in order to compensate for any deficits. Overall, participants ascribed similar meanings to their behaviour, such as to improve parental and sibling mood (e.g. P1: "so, I could see a smile on her face" (L9), P3: "made someone else feel good" (L403) , P4: "I want them to be happy"(L795), balanced family dynamics and secure family union (e.g. P1: "keeping the peace" (L236), P2: "…in order to retain my family together", P4: " to retain a calm environment" (L794), and avoiding punishment (P3: "I was scared of making mistakes because didn't want to get a beating"(L383).

Participants' supportive behaviour was explained by promoting the emotional and physical welfare of family members, as well as maintaining a family dynamic and union. This ascribed meaning emphasises the essence of the care-giving behaviour in which the child tries to compensate for any perceived deficiencies in the family. The inference drawn from

this supporting behaviour is that of a disproportionate demand upon the child's developmental ability by making it feel responsible for the security and well-being of the family. This theme emphasised the essence of parentification, in which the children lost some extent of their carefree childhood and adopted a parental attitude by feeling responsible for the family, a role otherwise assumed by parents. Moreover, this theme is consistent with Barnett's findings emphasising the child's readiness to comply in order to maintain feelings of security and well-being (2007).

Theme 4: Direct impacts upon the individual

The last theme identified in the experience of parentification was the direct impacts that parentification had on the trainees. Some participants explained how their early role influenced their wellbeing in childhood. This can be divided into 4 subthemes: 1) the conditional self-worth, 2) an increased sense of responsibility, 3) a tendency to neglect personal needs, and 4) emotional exhaustion.

With regard to the conditional self-worth, participants described how their care-giving role was valued by others, leading to a conditional self-esteem.

P3: "But then, it was praise and who doesn't like to be praised." (L354)

"…made me feel like I was being listened to and respected…made me feel good knowing that I'd made someone else feel good" (L399-L403)

P4: "In my family I felt good and worth by giving" (L809)

In addition, assuming a care-giving role developed an increased sense of responsibility for the well-being of others in the participants.

P4: "I became the responsible one" (L384)

P3: "…by being responsible for the emotional well-being of my family" (L879-L880)

In the process, participants learnt to sacrifice and accommodate their needs for the sake of others. The perceived meaning was that their needs were less important, where asking for support would be considered as a burden to others.

P4: "Accommodate myself according to their needs"; "in my family I haven't learnt how to take care of myself" (L797-L839)

P4: "…say no was a sign of selfish thinking in my family and giving beyond my capacities was rule for me…" (L885-L887)

P3: "People somehow forgot that I needed people too…I used to deal with my own problems by myself, because I didn't want to burden anyone else…" (L409-L411)

In addition, some participants felt that their role was beyond their capabilities and exceeded their capacities and resources, which in the long run led to emotional exhaustion and deficiency of emotional resources.

P3: "it comes to a point where I had nothing left to give. And I burnt out physically, emotionally and mentally. I shut down" (L765-L767)

P4: "…even when this was very difficult for me…as I felt that it was beyond my power" "…which made me more sensitive to burn out" (L786-L787)

In summary, conditional self-worth, increased sense of responsibility, a tendency to neglect of personal needs and emotional exhaustion were the main issues that some participants discussed in relation to their early role. The subtheme of conditional self-worth explored the observation that care giving became the condition of worth for some participants (P3 & P4), making their self-esteem dependent upon the individual's level of competence in care giving. This is consistent with studies speculating that parentified individuals may develop a caretaker identity due to the internalisation of a care giving role in their family (Valleau et al., 1995; West & Keller, 1991; Wells et al., 1999).

Further to the impact of conditional self-worth, the next subtheme referred to an enhanced sense of responsibility that participants felt for the well-being of family members. As has already been mentioned in the theme which referred to the ascribed meaning, all of the participants assigned a meaning to their supportive role. However, some participants (P3 & P4) described the perceived responsibility in terms of a burden. This mirrors the destructive nature of parentification when the level of responsibility is considered inappropriate for the developmental stage of the child, as suggested by Jurkovic (1997). In addition, conditional self-worth and increased sense of responsibility may overall lead to an increased care-giving behaviour which in the long run may challenge individuals' resources. In support of this, the last two subthemes described a neglect of personal needs and emotional exhaustion.

Some participants (P3 & P4) explained that familial demands prompted them to invest their resources in familial members, and at the same time conveyed the message of unimportance of personal needs. Thus, these participants learned to ignore their personal needs for the sake of others, leading them to low self-care, where emotional exhaustion was deemed inevitable. These findings are consistent with studies supporting the long term consequences of parentification with compulsive care- giving, low self-care and burn out (Glickauf-Hughes & Mehlman, 1995; Jurkovic, 1997; Valleau, et al., 1995;).

Overall, the first domain revealed that early conditions of parentification may create a need whereby individuals tried to respond to the family circumstances by adopting a supportive role. The supportive role depending on the related need, such as emotional and/or physical well-being of family members, will define the kind of support (instrumental and/or emotional) and its duration (contemporary or permanent support) required of the child. Participants were trying to enhance the emotional and physical well-being of their parents by offering various forms of support.

However, the experience and interpretation of parentification seemed to vary across participants. Participants 3 and 4 described a prolonged emotional and instrumental parentification, placed more emphasis on the importance of their role and perceived their experience as an important burden to their development, as they had extensively discussed the relative impacts on their psychological well-being. In contrast, participants 1 and 2 described a short duration of emotional parentification, and although they recognised an effect upon their behaviour, did not perceive it as a burden, as they have not reported any relative impact on their well-being.

The most obvious explanation for the above differences is that participants 1 and 2 have perceived their experience as more adaptive in comparison to participants 3 and 4, who perceived it as less adaptive or destructive. Participants' reports seemed to match with Jurkovic's classification with regard to adaptive/destructive distinction in which the experience becomes destructive when it is extended, and exhausts the developmental capacities of the child (Jurkovic, 1997).

In line with this model, the duration and the magnitude of the felt responsibility may influence the perceived impact of parentification. It is possible that the child's ascribed meaning and duration of the role may imply a primary or secondary importance of the assumed responsibility which in turn may determine the resulting impact. To put it differently, when the support is perceived by the child as of major importance for the welfare of the family, this may increase the felt responsibility and the felt burden. In contrast, when the supportive role is temporary it may imply a minor importance for the welfare of family, resulting in a shared or diminished responsibility which can be beneficial to the child's maturity. This suggestion is consistent with findings proposing that familial fairness in which care-giving is recognised and supported mediates the resulting impact of parentification (Jurkovic et al., 2005). However, due to the small sample size, further research is needed to

explore how the ascribed meaning of parentification and its perceived importance may influence its impact.

In addition, the differences among participants with regard to the perceived impact on their well-being can also be explained by the internalisation process of the parentified role. Participants 3 and 4, who experienced an extended parentified experience, had better chances to internalise a care giving role and identify themselves with a care giver's identity. In contrast, participants 1 and 2 who had experienced parentification for a shorter term had fewer chances to internalise and identify with a caregiver identity

Apart from the adaptive/destructive explanation, the differences among participants can stem from other factors that may influence the resulting impact, such as the child's temperament, capacity to care, attachment styles, level of self-differentiation and resilience (Hooper et al., 2011; Jurkovic, 1977; Winton, 2003). Previous research confirmed that the above factors may play an important role in the impact of parentification. Nevertheless, the first domain, which described the participants' parentified experiences, gave support to the bimodal impact of parentification.

Putting all of these together, these themes revealed the conditions under which parentification occurred, the forms of parentification, the meaning that participants ascribed to their parentified role and the impact participants experienced due to their parentified role. In addition, the duration of the supportive role and its perceived meaning are among the factors which can influence the resulting impact. This profile of parentification that trainees experienced will increase our understanding of the influences that their parentified experience had on professional development and practice.

Domain 2: The impact of early role on professional practice

The second domain of the analysis focused on the impact that the participants' early role in the family of origin had on their practice. Seven themes were identified and presented: 1) the choice of profession, 2) the choice of approach, 3) the enhanced empathy which became central to the identity, 4) boundary flexibility, 5) enmeshed client –therapist relationships, 6) creativity and 7) professional and personal development.

Theme 1: choice of profession

All participants expressed that their early role was later reflected in their choice of profession. The first subtheme that stemmed from the analysis was that the psychology profession seemed to be an extension of their early role. In agreement, all participants described the psychology profession in terms of familiarity and similarity with their early role.

P1: "… I guess being the one that tries to cheer up, to be emotionally present to others made me more prone to go for this profession because is more familiar…" (L13-L15)

P2: "…I was a forensic psychologist engaging in negotiation cases, so I got a lot of stuff negotiating between two hostile parties, hmmm..., I guess it comes in with the peace keeper I was as a child..." (L243-L246)

P4: "…so being a psychologist seems as a natural development of this early role". (L800-L801)

The second subtheme described the choice of the profession based on the development of a care-giving identity. The early role of trainees in providing support seemed to develop or shape a care-giving identity which led participants to follow a helping profession. However, participants 1 and 2, who suggested from the previous domain that they

had perceived their experience of parentification as more adaptive, did not make any reference to personal identity.

> P3: "So I guess I realised quite early on that I wanted to do something where I could help people… I'm quite a 'caretaker' and want to take care of those who need taking care of!" "If I had to put a label I'm say I was the responsible one, the caretaker" (L411, L426-L427)
>
> P4: "…I felt like trained from very early years to be in a helping profession…to be a caregiver …and to be sensitive in the emotional needs of others…" (L797-L799)

In summary, in the theme of professional choice, participants articulated as an extension of their early role and as fitting to the caregiver identity that they had developed through their childhood. The first subtheme proposes that parentified trainees may have already been greatly conditioned to provide support and have already acted as young psychologists in the family of origin providing solutions, sorting out arguments, and enhancing emotional well-being. Therefore, becoming professional psychologists was perceived as an evolution of this early role. This influence of parentification was apparent across all participants, proposing that, irrespective of the possible adaptive or destructive impact, early parentification may mould individuals to be more inclined to a helping profession. This is consistent with research proposing that early roles in the family of origin may extend through the choice of career (DiCaccavo, 2002; Fussell and Bonney, 1990; Nikcevic et al., 2007).

Moreover, some participants (P3 & P4) have already internalised a care-giving identity which seemed to catalyse their attraction to helping professions. This care-giving identity manifested itself in an increased responsibility for the well-being of others, care-

giving behaviour, and an increased perceptiveness of others' emotional needs which probably made them suitable candidates for helping professions.

Moreover, the subtheme of care-giving identity was reported only by participants 3 and 4, who seemed to perceive their experience as more destructive from the relative impact they reported. As has been mentioned above, a possible explanation may lie in the prolonged duration of parentified experience that participants 3 and 4 reported, which may imply that they had higher possibility to internalise and identify with a care giving identity. Theories of family and attachment seem relevant here in that in the long run parentification may be internalised by the child as a general interpersonal schema for relational patterns (Baldwin, 1992). Further, if care giving is what participants were praised for, (the subtheme of the conditional self-worth domain), then the maintenance of this behaviour may be vital for the stability of self-worth. This is consistent with Winnicott's theory of false self-development, and research findings supporting the idea that parentified individuals tend to present a caretaker identity in their relational patterns, ignoring their own needs (Valleau et al., 1995; Jones & Wells, 2000).

On the other hand, it is possible that the short term supportive role may have not been internalised in participants 1 and 2 minimising the identification of self with care giver identity. These findings were consistent with studies emphasising that adaptive parentification is linked with healthy differentiation from the family of origin and autonomy (Walsh et al., 2006).

Theme 2: The choice of therapeutic approach

Another important theme raised by some participants was the influence that their early role had on the therapeutic approach they chose to practice.

P1:" in therapy being more driven by the emotional side than more practical side, even reflected in the approaches that I feel more close to, like CBT which is much more behavioural side…I feel less close to it, because I am more in tune in the emotions rather than the behavioural side"(L22-L26)

P4: "I felt very close to approaches that analyse early years and searching for the underlying dynamics of early relationship … these approaches seem more meaningful to me..."(L820-L821)

Participant 1 described that on entering the training course she felt closer to emotion-focused approaches than behavioural ones, which she associated with her early involvement with emotions. Similarly, participant 3 reported her attraction to approaches focusing on family dynamics as they seemed more meaningful to her.

This theme proposes that some trainees may be attracted by therapeutic approaches which seem compatible and meaningful to their own history. This finding is consistent with the wounded healer concept proposing that the experience of the personal healing process may serve as a guide to healing others (Cain, 2000; Groesbeck, 1975). In addition, the personal experience of the therapist with the chosen therapeutic approach may enhance his understanding and expertise leading to more effective application of the specific approach. Also, the therapist's personal familiarity with a therapeutic approach may increase their faith in its utility, leading to more effective practice. However, due to the small sample size of the current study and as there are no comparable findings, further research is needed to verify the relationship between parentification and choice of theoretical approach.

Theme 3: Enhanced empathy

The third main theme of data was the enhanced capacity of empathy that was developed through the early care-giving role.

P1: "…not feeling empathy for them it will be strange for me" (L101-L102)

P2: "I think that is just the way I am..." (L309-L310)

P4: "to be empathic with them seemed as a natural skill...." (L831)

All participants described that early experiences had a significant bearing on the development of their empathic ability, which they later experienced as an integral part of their identity. Empathy was perceived as a defining trait of the self, whereas the absence of it was considered unusual. Moreover, the participants' explanations for the origins of enhanced empathy varied; therefore, three subthemes were identified to describe their responses. The three subthemes that captured the participants' responses were their early exposure to difficult experiences, the early demand of being empathic and parental empathy. Some of the participants described how their early exposure to different life experiences developed a familiarity and awareness to a variety of emotions which later gave them the ability to be easily empathic with clients' emotions.

P1: "I'll guess many life experiences will contribute to it, like...especially like loss, or bereavement, or separation and things like that will contribute to being able to put yourself in the other's people shoes and see the intensity of the emotion that somebody can have...". "…like, my parents have divorced when I was young as well, so and those intense kind of emotions in a household … helped me anyway to develop more empathy" (L82-L87, L92-L94)

P3: "Understanding how you feel when placed in different situations, when you're treated in a particular way… It's like, if you understand how different experiences make you feel, you will be able to respect how others may feel different things about their experiences"(L501-L502, L506-L509)

Still, some of the participants referred to the early demand of their environment to be empathic which consequently enhanced the development of their empathic ability. As

participants explained, empathy developed as a way to respond to familial difficulties and provide support.

> P1: "I think due to the role that I was playing in my family I needed to know that my mom wasn't well to want to help her, so, having somebody who is emotionally unwell in your environment will develop that skill anyway naturally..." (L87- L91)
>
> P4: "In my experience, I have learnt to be sensitive in the swings of others, and I have tried to put myself in their shoes…as a child… as a way of coping ....as a way to understand my environment…and that is why… I think that is something that comes from family." (L911-L915)

In contrast only one participant considered parental empathy as a factor in her enhanced empathy.

> P2: "…having a role model who is empathic with you…yes I think that affected me." (L295-L296)

In summary, the third theme identified was the enhanced level of empathy that participants experienced as a defining characteristic of their identity. All of the participants recognised the importance of early experiences in the development of their empathic ability, which they later experienced as a defining part of their identity. This suggests that the trainees' early supporting role fostered the development of empathic feelings to the level where empathy towards their clients felt as a natural process. This suggestion is consistent with research proposing that early involvement in family issues may equip individuals with enhanced capacities of empathy, making them good candidates for helping professions (Cain, 2000; Jurkovic, 1997).

Explaining further the origins of trainees' ability to be empathic to their clients, important differences among participants came to notice. For instance, participant 2 was the

only one to refer to parental empathy as an important factor in her enhanced level of empathy. The presence of parental empathy provides another support, in relation to the suggestion that has been made in the first domain, that participant 2 perceived the parentified experience as more adaptive. It seems that parental empathy may acknowledge and support the child's role which in turn fosters the development of the child's empathic ability.

The crucial role played by early caregivers in the development of empathy in children is echoed in this particular participant's expressed view and by Barnett's research (Barnett, 1987).

Moreover, the early familial demand, emotional attunement and involvement with others' emotional well-being may increase the possibility of the child to respond by developing higher levels of empathic ability as clearly articulated by Participants 3 and 4. This is consistent with research findings that anxious early attachment and parentified experience may give raise to a higher level of empathy and higher emotional awareness of other people's feelings (Fitzgerald, 2005; Trusty et al., 2005). Similarly, early exposure to a variety of emotions may enhance familiarity and awareness with different emotional situations which in turn may foster empathic understanding. The theme of enhanced empathy originating in the family of origin is consistent with the notion that emphasised increased relational skills and empathic abilities of wounded therapists (Jennings & Scovholt, 1999; Cain, 2000).

Theme 4: Boundary flexibility

The 4th theme identified through data analysis was the flexibility of boundary settings. Some trainees referred to their flexibility in setting boundaries which further supported their therapeutic utility. Specifically, some of the existing boundary crossings were

experienced as extreme by most of the participants and it did not feel appropriate to maintain them.

> P1: "some boundaries that have been set by professional bodies can be a little extreme, like the rule of touching, hugging and I don't usually tend to respect that, depending on the need of the client, which I feel is the need of the client…other… timing can be sometimes the one that is not respected fully"(L37-L41)

As participants maintained, boundary crossing has been therapeutically used for the benefit of their clients in order to provide reassurance, support, and learning.

> P3: "I had a session with a girl who used to get really angry so in the session we went for a power walk because she felt the need to get rid of the built up anger and frustration she was feeling. So rather than leave her sitting in the room we went for a walk and she learnt a way of helping her to manage the way she was feeling…(L440-L445)

> P4: "I have stroked the shoulder of a client and I have hugged a client in our last session as I felt that it was appropriate and I think it was only for the best…a sign that shows I am here for you",(L853-L856)

With regard to the development of flexible boundaries, some participants expressed that their increased sensitivity, empathy and responsibility towards the emotional needs of others, and consequently to their clients increased their flexibility to bend boundaries according to their clients' needs. Their increased sensitivity and responsibility made them more conscientious about the client's emotional needs leading them to accommodate boundaries accordingly.

> P4: "…for me to be sensitive and open to the emotions of others may lead me to cross some boundaries…so in my opinion boundaries need to be crossed only for the benefit of the client". (L859-L862)

Overall, some participants explained that their increased sensitivity and responsibility to clients' distress, which have been developed from their early interaction with family members, led them to be more flexible with boundary settings. Participant 1 was particularly articulate about this issue and spoke at length about the possible tension between maintaining boundaries and obtaining therapeutic benefits for the client.

> P1: "rather than just finish because the clock have said is finish, because you are so in tune with emotions…like I was with mom, and other member in my family, you just don't want to finish unnaturally"(L72-L75)
>
> P1: "because you want to be more, you want always to help more, you want to make sure that the person is safe, and all that stuff and sometimes boundaries don't allow for that (L201-L203)
>
> P1: I can see my empathy can be exaggerated, and impact on boundaries and then boundaries impact back empathy, so there is an interaction happening there (L220-L223)

Parentified trainees considered boundary flexibility as an ethical duty to their clients and expressed their humanness and deep involvement in the therapeutic process. Participant 3 even went as far as saying that: "…there are times when it feels unethical not to cross boundaries…" and "if it is for the benefit of the client it is ok to cross boundaries."(L431-L432)

As participants have already acknowledged in the previous theme, early training from family of origin conditioned them to be in tune with the moment to moment emotional shifts of clients, which in turn made their boundaries adjustable to the client's specific needs. This theme is consistent with Cain's findings proposing that wounded therapists may display an increased tolerance of a variety of clients' emotions and behaviours (2009). Although Cain's study did not refer directly to boundaries, we can assume that increased tolerance could only

exist under flexible boundaries in practice. It's worth noting that boundary rigidity has been proposed to increase alienation and rupture in therapeutic relationship (Lazarus & Zur, 2002).Therefore, parentified experiences may to some extent gift therapists with boundary flexibility, which is considered an important skill for therapeutic relationships. However, due to the current small size, and the lack of directly comparable findings, further studies are needed to verify the current theme.

Theme 5: Enmeshed therapist-client relationship

The 5th theme identified by data was the risk of forming enmeshed relationships. All participants identified that their early role in the family of origin may increase their risk to form enmeshed client –therapist relationships. Resources developed from their early role, such as increased sensitivity, over-responsibility and increased care giving may lead to an enmeshed role of rescuing the client, providing resolutions and assuming more responsibility

P3: "any crossing of boundaries needs to be well thought through. You can't just react, and just because I feel something or think of something doesn't mean that the client is thinking about it in the same way (L470-L473)

P3: I am the rescuer…always have been. So I do regularly have to check with myself the role I am playing in the relationship with clients" (L423-L426)

P4: "Sometimes, I found it difficult to step back and not take a dynamic role and to give back to them their responsibility" (L835-L837) "in the start of my practice it was very easy to forget myself and work harder than my clients"(L840-L842)

P4: "when our therapy did not have any progress anymore, as I could not find any other way to help her, I still found it difficult to end it…I found difficult to give up…at least I felt as giving up… (L868-L871)

P4: My difficulty to say no to a client made me to work extended hours and to cross my capacity …as I did when I was young" (L871-L873)

P4: "By being responsible for the emotional well-being of my family…I have felt the same with clients…the need to relieve them from responsibility" (L881-L83)

In the theme of enmeshed client-therapist relationships it became evident the presence of early parentified role, independently its perceived destructiveness. All participants indicated a concern about transferring their early role in therapeutic relationships which could minimise their therapeutic neutrality leading them to enmeshed relationships as expressed by Participant 2.

> "Sometimes I found it difficult not to take sides and not to draw into their dynamics. I found it difficult not to try to resolve issues and remain in a psychologist's position instead of a peace maker" (L248-L251)

The internalisation of early relational models to further relationships discussed in family and attachment theories is of relevance here with this particular theme (Byng-Hall, 2008). Especially in therapeutic relationships the transference of an early care-giving role can be more evident, as the parentified therapists are called again to provide emotional support and containment without reciprocity. In addition, as boundary flexibility was evident with more distressed clients, it is possible that distress clients due to their vulnerability may be more likely to activate parentified roles in trainees.

This raises an important consideration for all therapists who have experienced parentification, even if it was an adaptive one. The early role of peacemaker, the rescuer, and the caregiver when transferred to therapeutic relationships will inevitably sabotage the therapeutic objectivity and impair therapeutic effectiveness. It should be noted that some participants were clearly aware of the impacts of such implications on their practice. The theme of enmeshed therapeutic relationships by transferring early roles is in agreement with

findings proposing that parentified therapists may display a compulsive care-giving stemming from an early role in the family of origin (DiCaccavo, 2006; Valleau et al., 1995).

Theme 6: Creativity

The 6th theme identified was the increased creativity that their early role had to offer to the participants. Some participants explained how during their early efforts to support their parents, they experimented with different approaches to the problem, which increased their ability to use creative ways to help others.

> P4: "like when you are a child and you really want to help your family and you try different things that may work…I think a skill I use a lot in therapy…as I always search for alternative ways of helping my clients"(L963-L966)
>
> P1: if my mom was not well and I was trying to make a joke and it didn't work, and then I tried to bring a bunch of flowers or so and that might work and you trying a lot different skills, so it makes you think more creatively to potentially help the person you are trying to help"(L227-L231)

Early efforts to discover alternative ways to provide support cultivated an increased resourcefulness that became valuable for their therapeutic practice. Creativity in therapeutic work may help the therapists to go beyond the conventional practices and apply different techniques to accomplish therapeutic outcomes. This theme is consistent with clinical observations that parentified children in their efforts to discover alternative ways to provide support develop increased creativity and coping skills in supporting their parents (Hooper et al., 2008; Jurkovic, 1997). This theme seems to echo the findings that wounded therapists reported an increased incorporation of models of empowerment and recovery, which may signify higher therapeutic creativity (Cain, 2009).

Domain 3: personal and professional development

The last domain identified by the data was the importance of personal and professional development as a protective factor to the difficulties that the early role brought to therapy. Specifically, this domain consisted of 3 themes: 1) increased awareness of the tendency to transfer early familial roles in therapeutic relationships, 2) increased attention to self-care and 3) increased self-other differentiation. With regard to the first theme, personal and professional development increased the therapist's awareness of their early tendency to want to rescue, provide resolutions and acquire responsibility for others' happiness, which helped participants to step back and monitor their therapeutic involvement.

> P3: one is only and solely responsible for themselves, so this helped me not to become enmeshed in relationships (L485-L487)
>
> P4: "… personal therapy and supervision increased my awareness of this tendency and helped me to become a therapist and not a rescuer" (L955-L957)

In addition, personal and professional development was identified by the participants to increase their awareness of self-other differentiation which helped trainees to keep a therapeutic distance minimising emotional enmeshment.

> P3: "maintain a certain level of healthy detachment and a sense of my individual self. And so when I am in a therapeutic relationship it helps me in the sense that I know this person is hurting but their pain is not my pain. Even if we may have similar themes in our life story, I can separate their stuff from my stuff" (L488-L493)
>
> P4: "I have learnt to help them develop according to their own values and beliefs…and not fulfilling mine…" (L897-L898)

Still, personal and professional development increased trainees' awareness for self-care and to minimise the risk of exhausting personal resources.

P3: “After 30 years I have now learnt that I should not do things for others at my own cost all the time. Sometimes I need to keep a little back just for me” (L767-L769)

P4: “however supervision and personal therapy helped me to see my need to give and increased my awareness on self-care” (L842-L844)

Overall, the last domain referred to the protective factor of personal and professional development in the reported impact of early role in the family of origin. Again, this theme reflected the variations in manifestations of parentification among participants, as only participants 3 and 4 explicitly referred to the importance of personal and professional development in overcoming their early role difficulties. It is worth mentioning, that participants suspected to have more adaptive forms of parentification did not make any reference to any personal and professional development when discussing the early role. It is probable that the more adaptive experience of parentification may have had fewer repercussions on the therapeutic work raising little attention and few difficulties to the trainees. However, is still possible that these participants may be less aware of such impacts on their practice.

Nevertheless, personal and professional development increased awareness of early relational patterns and helped the practitioners to monitor their role in therapeutic relationships. In addition, it promoted self-other differentiation and self-care in some parentified participants. Parentified trainees seemed to have learned to neglect personal needs and to use all of their resources in the service of others, whereas engaging in personal and professional development helped them to balance their giving and increase their self-care. The importance of self-care as absolutely imperative for mental health professionals identified by Halewood and Tribe (2003) is iterated in the current study. Self-care strategies are necessary in order to prevent psychological distress from causing impairment in practice.

In addition, self-other differentiation increased trainees' ability to remain empathic, but without over-identifying themselves with the pain of others, thus increasing their ability to retain therapeutic objectivity. Self –other differentiation has also been raised in Cain's study that looks at self-client identification in the wounded therapists' countertransference (2000). The protective utility of personal and professional development seemed to highlight the potential for parentified trainees to harvest their talents acquired through their early role and to control for any negative impact. However, the protective role of personal and professional development in the development of parentified trainees would warrant further exploration.

Adaptive /destructive impact across domains

Summing up all the domains, an important observation became obvious. The variations identified in parentified experience and their relative direct impact (the first domain) was reflected in the descriptions with regard to professional practice in terms of boundary and empathy. However, in professional practice the differentiation seemed to be less profound. In specific, parentified trainees, who have been suspected (from the first domain) that they may perceived their early experience in a more destructive way, differentiated their responses from those that were more adaptive, only in regard to the choice of the profession by referring to the explicit internalisation of a care giving role in their choice of profession, as well as the benefits received from personal and professional development.

A possible explanation for the less profound differentiation between the reported impacts may lie in the fact that participants 3 and 4, who might have perceived their experience as more destructive, were the ones reporting the need and the benefits of personal and professional development, as a way to moderate the relative impact. In other words, it is most probable that without the process of reflecting their early experience in personal and

professional development the differentiation among destructive /adaptive impact could have been more evident. Also, the need of participants to receive support in order to increase self-care, self-other differentiation and awareness of transferring early roles into therapeutic practice, is by itself an important indicator for the presence of a more destructive impact. In other words, the need of participants to address and minimise the relative impact of parentification may signify its destructiveness.

In conclusion, the current study identified the common circumstances that fostered parentification, which are further reinforced by the intrinsic characteristics of the child. Then, the quality, the duration and the ascribed meaning of a parentified role may jointly determine the relative impacts that it will have on the child. When the experience of parentification is perceived as more destructive, the individuals reported a conditional self-worth, an increased sense of responsibility, a neglect of personal needs, and emotional exhaustion.

Following the impact of parentified experience in professional life, the current study found that parentification may first of all catalyse the choice of a helping profession, as an extension of the early role, as well as the choice of psychotherapeutic approach, which may be influenced by the meaning that is conveyed by the trainee's early history. Proceeding to the interpersonal skills, parentification may positively impact the development of enhanced levels of empathy, boundary flexibility, and creativity. In addition, parentification may also negatively impact on practitioners by making them more vulnerable to enmeshed therapeutic relationships and boundary distortions, irrespective of the degree of parentification. However, when the parentification was experienced as more destructive, there was a profound need for personal development and professional support that would minimise the risk for increased emotional enmeshment, low self-care and self-other identification, by increasing the trainees' awareness of impacts of parentification on their therapeutic practice.

Therefore, parentification may have a bimodal impact on professional practice, and it is not inherently pathological. On the contrary, parentification under more optimal conditions may enhance important talents of trainees, especially for their therapeutic effectiveness. However, under inappropriate conditions, parentification may, parallel to those skills, discourage important developments such as self-care and self- other differentiation, which may compromise the overall therapeutic effectiveness.

Clinical implications

The current study aimed to examine the role of parentification in therapeutic practice which entails important implications for clinical training and practice. Parentified experience seemed to have both a positive and/or a negative impact on therapeutic work. As characteristically pointed out by a participant, parentification can be "a thorn in their side or a blessing in disguise (P3)". This phrase seems to reveal an important meaning for any traumatic experience. Adversities can be detrimental for the individual who experiences them or they can become an important chance for growth and development. The way individuals make sense of their adversities can further traumatise them or help them to expand their potential. The knowledge in relation to possible vulnerabilities, which parentification may bring to the therapeutic profession, will raise the awareness of parentified therapists, which may in turn increase their ability to monitor and evaluate their roles and countertransference in therapeutic relationships.

The awareness of their own talents and vulnerabilities in parentified trainees is crucial not only for the practitioner in question but also for the training of educators and supervisors. As participants explained, personal and professional development played a catalytic role in utilising their talents and control for any vulnerability. Boundary flexibility, increased empathy, and creativity can be encouraged by training and supervision, whereas monitoring

for emotional enmeshment, self-other differentiation and self-care will ensure best practice and unfold trainees' therapeutic ability.

More specifically, clinical supervision may play an important role in utilising a parentified therapist's capacity to be empathic and control for empathic over arousal by monitoring the balance between empathy and maintaining boundaries. In the same way, supervision can closely attend minor boundary transgressions in order to evaluate their therapeutic effectiveness and utility, minimising the risk for potential boundary violations.

Moreover, it is important that parentified therapists get enough holding and containment to understand their history of parentification and attune to their own wounds. Understanding the possible impact of parentification will increase the importance of personal therapy and development which will address in a more therapeutic way unresolved issues and unmet needs of therapists. Personal therapy will help the parentified therapist to accommodate his or her emotional needs, and unresolved conflicts which will prevent emotional enmeshment with clients. In this way parentified therapists will be able to use their 'inner healer' wisely to benefit their therapeutic work. Moreover, the increased awareness of the parentified self and other in a helping relationship may prevent the overuse of caretaking role which leads to enmeshed therapeutic relationships.

Also, training programmes should be proactive in educating trainees for the relative impact of boundary violations, as well as for the potential danger of repetitive boundary crossing in order to promote ethical practice. In essence, personal therapy, training and supervision may prepare parentified trainees for the challenges they may face due to their history by expanding their potentials and managing their difficulties. In addition, the supervisor's awareness of parentification will inform their role in how to identify and harness experience of parentification in trainees in order to use it constructively as a therapeutic instrument.

Overall, the therapeutic relationship is now recognized across theoretical approaches as being one of the important conditions for implementing therapeutic change. Consequently, boundary setting and empathy, as elements of a therapeutic relationship, need to be addressed, irrespectively of the theoretical approach. Therefore, parentification could be considered a transtheoretical concept that can be utilised by all trainees.

Limitations of the current study

Even though the findings of the current study provide important insights for the training and practice of the psychology trainees, it is important to interpret them with caution. The most important limitation of the current study was the small sample size which minimises the generalisability of the results. Although the purpose of the qualitative part was to provide a further analysis of the relations among parentified roles and relational therapeutic skills, further study with a larger sample could analyse in more depth the above concepts and verify current themes.

Another possible limitation is that trainees were asked to discuss sensitive concepts in regards to their practice, which may have attenuated the depth of responses to the interview questions. In addition, further studies are needed with participants who vary in their degree of parentification in order to shed light on the complexity of how experience of parentification influences one's wellbeing in general and therapeutic practice in particular.

Finally, even though we considered our biases and expectations throughout the study, it is still possible that they influenced the questions in the interview and how we coded and interpreted the data. Therefore, future research is needed in order to examine further and in more depth the current themes.

Overall Discussion

Combining both studies, the current research provided an important support for the concept of a wounded healer. Quantitative analysis of the survey study revealed a more general view with regard to the relationship among parentification, trainees' level of empathy and professional boundaries, whereas qualitative analysis of the interview data offered an insight into how these relationships are perceived by the trainees. Specifically, the findings of the survey study confirm that parentification could explain variations in the levels of trainees' empathy to some extent. This was further supported in the thematic analysis of the interviews with trainees. Trainees' early parentification was seen by most to enhance their capacities to be empathic via early exposure to a variety of emotions as well as their efforts to respond to early familial demands. In addition, the thematic analysis revealed that parentified trainees, who may have perceived their experience as more destructive, due to the low self-other identification, may be more prone to emotional enmeshment with clients.

Moreover, the survey study observed that parentification can explain some variations in professional boundary transgression. The interview study lends further support to such a relationship in that the trainees interviewed explicitly discussed how their early parentification may have cultivated an increase in sensitivity, care-giving and responsibility, which in turn enhanced their ability to remain flexible with their boundary settings. In addition, the qualitative study supported that parentification, irrespective of its perceived destructiveness, may lead to enmeshed therapeutic relationships. In the case of a more destructive parentification, the presence of low self-care and low self-other differentiation may increase the potential risk for enmeshed relationships, whereas further development could minimise the impact.

Furthermore, the survey study found that empathy has its significantly unique contribution to account for variations in boundary transgression to some extent, after the

effects of parentification were controlled for. The trainees interviewed in the qualitative study openly articulated their views on boundary flexibility and how their heightened sensitivity to others' emotional needs may lead them to be more concerned with the clients' needs instead of maintaining strict boundaries. However, such a therapeutic approach if left unchecked is likely to lead to emotional enmeshment and boundary violations. The importance of personal and professional development in keeping such a tendency in check was also discussed by some participants.

In sum, findings from the two studies presented here were by and large consistent with each other, and together provided a more integrated understanding of the bimodal impact of parentification. The survey study provided a general direction for the relationships among the variables, as well as offered significant suggestions for the predictive power among them. Added to this, the qualitative study provided a more in depth exploration of how the trainees perceived the above relationships, especially in regards to the therapeutic utility of parentification.

Overall, the above findings provide further support to the concept of wounded healer, emphasising the importance of personal woundedness, as a way to increase sensitivity and empathy to the emotional pain of others as well as the importance of the healing process that could inform and guide others' healing. Nevertheless, the current research raised important considerations not only for clinical practice but also for training and supervision. Awareness and understanding of the manifestations of parentification in both trainees and supervisors could enhance trainees' and supervisors' attention on minimising its vulnerabilities and utilise its gifts.

Taking into consideration the limited research on the impact of parentification on professional practice, the current research provides an important contribution by examining and verifying previous theoretical and clinical suggestions. The current findings provide

significant and specific implications of parentification with regard to the interpersonal skills of empathy and boundary crossing. Nevertheless, taking into account the aforementioned limitations of using different research methodologies the following section proposes some suggestions for future research.

Future Research

Taking into consideration the above findings, further research is needed to account for current limitations. Although the relationships among parentification, empathy and boundary transgressions on therapeutic practice were established in the survey study, the relationships were moderate with only limited variables included in the models. Further studies should consider involving a greater number of participants, as well as taking demographic characteristics into consideration. Moreover, further research is needed that could verify the trainees' self-reports of empathy and boundary abilities by including clients' validations. In addition, the current study focused upon a particular narrow group, namely psychology trainees, and therefore the results may not be generalised to all parentified practitioners. For this reason, replicating the study in qualified and more experienced practitioners may further reveal more varied manifestations of parentification in therapeutic practice.

Furthermore, future examination is needed in order to identify other factors which may mediate the susceptibility of parentified professionals to boundary transgressions, such as self-other differentiation and emotional regulation. More importantly, the pressing issues related to measurement limitations should be more thoroughly examined in future research. Although the questionnaires chosen for the current research are the most appropriate for the current project amongst those available, all questionnaires lack a degree of psychometric validity. More refined questionnaires should be developed to discriminate between adaptive and destructive parentification, as well as for boundary crossing and violations.

Based on findings observed in the thematic analysis with the four trainees, more extensive research using more in depth analysis approaches such as grounded theory, may offer a more detailed understanding on the research in question. In addition, further qualitative research is needed to explore the clients' perspectives in order to triangulate with the therapists' own perspectives on empathy and boundary flexibility.

Additionally, the pitfalls and benefits of combine both quantitative and qualitative methods in a mixed design should be further examined. How the tension between balancing objective measure in unique contributions in comparison to research that employs a singular epistemological approach.

Conclusion

The overall aim of the research was to identify and understand the possible talents and vulnerabilities that an early history of parentification can bring to therapeutic practice. According to the researcher's knowledge, although suggestions of talents and vulnerabilities in parentified practitioners are often made in theoretical studies and clinical findings, the research on parentification is limited and mainly restricted to researching the prevalence of childhood adversities and then theorising about their potential impacts. Taking into consideration the above gap, using a mixed methods design, the current study provided firm empirical support by identifying the talents as well as the vulnerabilities of parentified therapists in professional practice with both objective measurements and subjective discussion with trainees.

All findings considered, parentification may cultivate in trainees an enhanced capacity for empathy, responsibility and care-giving. In turn, this may influence trainees' choice to enter the profession and to choose a 'meaningful' therapeutic approach, promoting boundary flexibility and increased empathy, leading to a more humanistic view of practice. Indeed, if their early history of parentification is not attended to, it could lead to emotionally enmeshed therapeutic relationships and increased boundary transgressions, which may compromise overall their therapeutic effectiveness. Nevertheless, professional and personal development could act as a protective factor for parentified trainees by controlling for early role transference in therapeutic relationships and by increasing trainees' self-care and self-other differentiation.

Finally, the current study provides an important support to the concept of the wounded healer, by emphasising the important legacy that personal wounds can bring to therapeutic practice and by recognising the healing process as a way to expand this

potentiality for client healing. On the other hand, limited awareness of the potential impact of unattended wounds could make the therapists just wounded and not healer.

Critical Appraisal of the Research Process

The journey in writing this dissertation has been wonderful and challenging. The inception of this research came some years ago while wondering about the impact that parentification had on myself. Two important sources of inspiration, 'The Drama of Being a Child', by Alice Miller and 'Families and How to Survive them", by Skinner and Cleese were the first books that helped me to understand and explain my personal experience with parentification. Even though the understanding was a bit rudimentary at those times, it helped me to unfold the dynamics in my family.

My personal development before entering the course was mainly around understanding and accepting my lost childhood. The personal journey of healing led to the discovery of a true self which does not need to be disguised or to remain hidden in order to maintain others' happiness. I have learnt and I always remind myself that we are solely responsible for our own happiness. Even though as therapists we can guide and facilitate a therapeutic process, the choice and the path of healing is a journey that we cannot walk in the place of others. A personal thought is that maybe therapists don't really heal clients; they just teach them how to heal themselves and stand next to them as a supportive witness of their transformations.

Further, upon entering the course and starting to practise, I realised that some wounds that had been healed were to be challenged again by the intense dynamics of therapeutic relationships. I am extremely grateful to my supervisors, that my training was a journey of awareness and understanding, through which my early loss transformed into a gift that I could use for the benefit of others. The acceptance and the awareness of the self which I bring into a therapeutic room, may never eliminate my personal countertransference, but I have

developed the ability to not allow it contaminate the therapeutic process. This brief self-reference can partially explain my internal motivation surrounding the topic.

Nevertheless, my decision to investigate parentification was further stimulated by clinical practice. I am unsure if the meeting with specific clients was accidental, but in my practice I dealt a lot with issues of parentification impacting my clients' professional practice. A characteristic example was a specific client of mine, a social worker, who suffered from emotional exhaustion and burn out due to the excessive care giving and low self-care. It seemed that the unmet needs for intimacy and caring were projected into her clients, intensifying the wish to rescue them. Her poor skills of self-care lead to emotional exhaustion and burn out. The presence of an extreme destructive form of emotional parentification was evident in her family of origin, whereby our work together inspired even further the interest in investigating how this early experience influences helping professionals.

The decision to choose this topic was followed by intense reading around parentification, wherein the numerous terms that have been used in the literature to describe the same process make the gathering of relevant literature especially difficult. Another important issue was to distinguish between theoretical considerations and research based findings. Through the literature, many studies have investigated the prevalence of traumatic experience and role reversal among psychologists in which the researcher further speculated a possible impact of these experiences, but very few studies have focused on the impact per se. Therefore, the current proposal was to investigate directly the impact of early parentification on the professional practice of psychologists.

Moreover, the concept of the wounded healer heavily influenced the theoretical orientation of this study. In my training I was lucky enough to shadow charismatic therapists, and questioned the origin of their talents. Their ability to admit to their own wounds

strengthened my belief in the concept of the wounded healer, which underpins this research project.

Another major issue in the current research was the choice of methodology. Having a quantitative background as a researcher, the possible choice of a qualitative method was dealt with cautiously. Conducting a quantitative study offered the ability to generalise the results, and provide an objective finding. On the other hand, relying exclusively on a quantified measure may run the danger of missing out important information that one could access only through studying the personal experience of the parentified psychologists. The above considerations shifted the attention to a mixed design, which offered the advantage of a more complete picture for the topic of interest. Still, the important disadvantage of a mixed method is that it was time consuming as it demanded an extensive knowledge of both approaches, the gathering of data for two separate studies, as well as an additional challenge of synthesising the results of both studies.

In practice, conducting a mixed design proved to be especially time consuming. In the quantitative part, the choice of the instruments proved especially challenging, particularly the one for professional boundary transgressions, due to the scarcity of measurements. Also, the boundary transgression questionnaire does not have a clinical cut-off point to separate boundary violations from boundary crossing, which could account for either therapeutic effectiveness or malpractice, making the interpretation of the direction of the results difficult. In addition to this frustration, the questionnaire used on parentification also does not have an official cut -off level to separate between parentified or not, minimising the choices in statistical analysis.

Moreover, in the qualitative part, the design of interview questions was also challenging, in that the questions chosen should not lead the participants but at the same time they need to be specific enough to minimise the risk to gather vague information. The

inexperience of taking an interview was feeding even more my anxiety of having appropriate design. However, the use of a pilot study provided a valuable insight and feedback. First, the pilot study helped to identify ambiguities and difficult questions, and to discard the unnecessary ones. Pre testing the questions gave an important insight to whether each question gave an adequate range of responses, as well as whether possible replies can be interpreted in terms of the information that is required. Second, the pilot study helped me to evaluate the time needed to complete the interview and decide whether it is reasonable or not. Overall, the use of the pilot study provided valuable information in order to shorten, revise and increase the utility of interview questions.

Proceeding to the gathering of data, the quantitative part was more time consuming in terms of finding a sufficient number of participants, whereas for the qualitative part the anxiety was on conducting interviews that would provide sufficient information. In addition, the actual process of interview was also difficult, taking into consideration the sensitivity that the topic demanded in order to avoid putting the participants into a difficult emotional situation. Understanding how uncomfortable it can be to discuss topics within professional boundaries in association with early difficult experiences, I restrained myself from asking for more clarifications or deeper insights, leaving the decision to the participants to reveal as much information as they chose.

Whereas the analysis of the results seemed relatively easy in the quantitative part due to previous experience, the qualitative part seemed more difficult to analyse. As the qualitative research was used as an explanatory study, a thematic analysis was used. However, as the impact of parentified experiences was varied among participants, the resulting impact was varied too. Therefore, the themes that have been identified were based more on the importance they seemed to hold for each participant instead of the prevalence of each theme amongst the participants. In addition, the small number of participants reinforced

even further the above decision, as it was more difficult to identify common themes among four participants. However, the small number of participants gave the opportunity to detect how the reported differences in parentified experiences may have differentiated the impact on professional practice.

An important aid was obtained by the evaluation of the themes from an objective researcher who provided valuable feedback for the validation of the themes. The external evaluation offered a more objective view of the findings and these insights helped me re-evaluate the findings. Moreover, throughout the research, supervision was a source of support and knowledge. The supervisor's experience helped me to keep a more objective stance and she supported me with her encouragement, knowledge and advice. In addition, supervision had the effect of increasing my critical stance towards current findings, and it also supported the appropriate presentation, coherence and consistency of the argumentation. Furthermore, supervision was a source of stimulation and the exchange of ideas helped me develop further as a researcher.

Concluding this research seemed a time consuming process which in association with the parallel training seemed especially challenging. Throughout the process, I have learnt to accept the uncertainty of making choices without definite answers and contain my fears of not being able to complete it. The multiple demands of the training also required a lot of effort and concentration, leaving fewer resources for the attention that a research project demands. In addition, important life events that occurred during the training challenged my dedication and discouraged my faith in concluding this research at times. These experiences however strengthened my ability to sustain ambiguity and find the strength not to quit. Nonetheless, pulling myself between making it better or getting it done seemed an endless process. There was always something that I could do in order to make it better. This increased my ability to accept its imperfections and deficiencies and to believe that it was my best

effort under the current circumstances. I hope that this research will stimulate further discussion about the talents of wounded healers, eventually leading to a greater degree of psychological understanding of the therapeutic self.

Concluding this study I gained an important experience of conducting a research project and it has taught me how to take into consideration different factors and operate as a researcher. Without question, it was a valuable experience as it offered the knowledge and the skills which a counselling psychologist needs for researching any further topic in his or her career. In the process, I have gained the experience to think creatively and to keep a critical stance in the process of reviewing the literature. In addition, it gave me a specialised knowledge in statistical and thematic analysis. As a practitioner, conducting this research I have gained important specialised knowledge about the topic of role reversal which is important for my practice. It also reinforced my awareness of the importance of monitoring personal wounds as I could otherwise risk impeding the therapeutic process with my clients.

Still, this research gave me a great sense of achievement and confidence as a researcher. My experience with both research methods would offer me the ability in the future to make choices according to the most appropriate methods without fear of inexperience. In addition, I feel that my research provides an important contribution for the parentified counselling psychologists, as well as for the clinical supervisors as it informs them of specific vulnerabilities and talents that they may be going to be challenged with.

Overall, this process developed my professional identity as a researcher and gave me the opportunity to investigate an important topic, as well as to make a personal contribution to the understanding of the concept of the wounded healer. Although conducting a research project is a very challenging and time consuming process, it offered an important opportunity not only to increase my skills as a researcher, but also to develop a critical stance as a reader

in other studies. The journey of research may be full of adventures and difficulties, but it is valued by the gift of knowledge that it offers.

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Appendices

Appendix 1

UNIVERSITY OF WOLVERHAMPTON

RES 20A
(October 2003)

School of Applied Sciences
Behavioural Sciences Ethics Committee:
submission of project for approval

To be completed by SEC**:**
Date Received:
Project No:

- **This form must be word processed – no handwritten forms can be considered**
- **ALL sections of this form must be completed**
- **No project may commence without authorisation from the Divisional and School Ethics Committees**

CATEGORY A PROJECTS:

There is no significant interference with participants' physical or psychological wellbeing. In detail:

• The research procedure is not likely to be stressful or distressing.

• The research materials are not of a sensitive, discriminatory or otherwise inappropriate nature.

• The participants are not members of a vulnerable group, such as those with a recognised clinical or psychological or similar condition.

• The research design is sufficiently well-grounded so that the participant's time is not wasted.

Projects involving access to confidential records may be considered Category A provided that the investigator's access to these is part of his/her normal professional duties.

Category A projects will be approved by the Behavioural Sciences Ethics Committee and monitored by the School Ethics Committee. The School Ethics Committee will not normally examine individual Category A projects but receives a record of projects that have been approved at subcommittee level.

Title of Project:	Therapist: from family to clients
Name of Supervisor: (for all student projects)	Dr. Josephine Chen-Wilson
Name of Investigator(s):	Isidora Begni
Level of Research: (Module code, MPhil/PhD, Staff)	Professional Doctorate in Counselling Psychology
Qualifications/Expertise of the investigator relevant to the submission:	Ba (Hons) in Arts Graduate Diploma in Psychology Research module(s) on doctorate programme

Participants: Please indicate the population and number of participants, the nature of the participant group and how they will be recruited.	The first part of the research (questionnaire study) aims to recruit 50 psychologist trainees from counselling psychology courses, without any segregation of gender, or ethnicity. The 50 participant will be recruited through a research advertisement on BPS site (Appendix 1). The second part of the research will consist of 6 -9 psychologist trainees who are willing to explore their experience of parentification and its impact on their professional practice, in a semi-structured interview. Participants in this follow-up study will be recruited among the ones who have clearly shown inclination to partake through the first round of recruitment.

Continued overleaf

Please attach the following and tick the box* provided to confirm that each has been included:

**in the case of undergraduate projects, this should be done by supervisors to confirm that each part is properly constituted*

Rationale for and expected outcomes of the study	√
Details of method: materials, design and procedure	√
Information sheet* and informed consent form for participants **to include appropriate safeguards for confidentiality and anonymity*	√
Details of how information will be held and disposed of	√
Details of if/how results will be fed back to participants	√
Letters requesting, or granting, consent from any collaborating institutions	√
Letters requesting, or granting, consent from head teacher or parents or equivalent, if participants are under the age of 16	
Is ethical approval required from any external body? ~~YES~~/NO (delete as appropriate) **If yes, which committee?** *NB. Where another ethics committee is involved, the research cannot be carried out until approval has been granted by both the School committee and the external committee.*	

Signed: Date: 30/05/10

Isidora Begni

(Investigator)

Signed: Date:

(Supervisor)

Except in the case of staff research, all correspondence will be conducted through the supervisor.

FOR USE BY THE SCHOOL ETHICS COMMITTEE

Subcommittee Approval Granted: ---------- (Chair of Behav Sci Ethics Committee) ----------

Date: ----------

School Approval Granted: ---------- (Chair of School Ethics Committee)

Date ----------

Appendix 2

Advertisement of the study on the BPS site for research participants

Therapist: From family to clients

I am undertaking research for the Professional Doctorate in Counselling Psychology at Wolverhampton University. I am seeking counselling psychologists in training to take part in a study that explores the impacts of parentification (role-reversal in childhood years) on professional practice. This study involves completing 3 questionnaires and the whole process takes about 20 minutes. Your participation in this study will contribute to increasing the awareness of parentification and its impacts on therapeutic practice.

If you are interested in participating, or to find out more, please email me: i.begni@gmail.com. This research has been approved by the Ethics Committee in the School of Applied Sciences at Wolverhampton University and is being supervised by Drs. Josephine Chen-Wilson and Yvette Lewis.

Isidora Begni

Trainee Counselling Psychologist

University of Wolverhampton

Appendix 3

Informed consent form for the questionnaire study

Therapist: From family to clients

Purpose of the study

This study aims to examine how parentification might affect therapeutic work with clients by looking at the extent to which the role in the family of origin might influence boundary setting and empathy in therapeutic work. The findings would be beneficial to the practitioners' professional development at a variety of levels of training or practice.

What is involved

Participants will initially be asked to complete three questionnaires: the Parentification Questionnaire that indicates their role in the family of origin, the Exploitation Index Questionnaire that indicates boundary crossing in practice and the Emotional Reactivity Questionnaire that measures the levels of empathy. The time to complete the questionnaires should be roughly 30 minutes. Participants will also be asked for permission to be contacted for a follow-up study by the same researcher. However, such an indication is not compulsory nor does it indicate consent to participate.

If you wish to participate please complete the following consent form and return it to the researcher.

Consent Form

I have read and understood information on this consent form, and I agree to participate in the study conducted by Isidora Begni. I understand that all information collected in this study will be kept confidential and anonymous. I am assured that no individual information will be identified in the results or future publication of the results. My participation in this research is voluntary, and I may withdraw at any time without giving reason.

I am aware that the data will be securely locked up in a cabinet for 5 years, and will be destroyed thereafter. The results of this study will be shared with others through the completion of the Dissertation and potentially in a published paper.

I am aware that there are no predictable physical or psychological harms associated with participating in this study. However, participation in this study may cause me to experience some unpleasant emotion or recall some unpleasant experiences. I understand that I am completely free to refuse to answer any questions.

☐ Please tick the box to give your permission for us to contact you in a follow up study.

Signature of participant _____

Date _____

Appendix 4

Information Sheet

Dear Madam/Sir

I am conducting a study into the impacts of parentification on professional practice as part of my practitioner doctorate in Counselling Psychology at the University of Wolverhampton. This study is to examine how parentification might affect therapeutic work with clients especially boundaries and empathy. The objective is to increase awareness about how a counsellor's role in her/his family might impact on their therapeutic work.

You are invited to partake in this study by completing three questionnaires that look at the extent of your role in the family of origin, the levels of your empathy and the level of professional boundary crossing.

This study has been approved by the Ethics Committee in the School of Applied Sciences, University of Wolverhampton. Please be assured that personal information and the results will be kept confidential and secured throughout the study. At the end of the research, the data will be stored securely and anonymously, for five years. No individual will be identified in any publication of the results.

If you would like further information about the outcome of the study, please feel free to contact me via email and an abstract will be sent to you when this study completes. If you wish to take part in this study please complete the consent form enclosed and return it to the address enclosed.

Your help is greatly appreciated.

Yours faithfully,

Isidora Begni

Trainee Counselling Psychologist

University of Wolverhampton

Appendix 5

Informed Consent Form for Counselling Psychologist Interview
Therapist: From family to clients

Purpose of the study

This study examines how parentification might affect therapeutic work with clients by interviewing trainee counselling psychologists.

What is involved

A one-to-one interview with the researcher will explore how the role in the family of origin influences one's practice with clients. The interview will take place in a private office setting and will last approximately 60 minutes, as well as 10 minutes for debriefing afterwards. The interview will be audio recorded in order to allow the researcher to transcribe it and analyse it later.

Please complete the following form and return it to the address specified.

Consent Form

I have read and understood information on this consent form, and I agree to participate in the study conducted by Isidora Begni. I understand that all interviews will be kept confidential and anonymous. I am assured that no individual information will be identified in the transcript or future publication of the results. My participation in this research is voluntary, and I may withdraw at any time without giving reason.

I am aware that the data will be securely locked up in a cabinet for 5 years, and will be destroyed thereafter. The results of this study will be shared with others through the completion of the Dissertation and potentially in a published paper.

I am aware that there are no predictable physical or psychological harms associated with participating in this study. However, participation in this study may cause me to experience some unpleasant emotion or recall some unpleasant experiences. I understand that I am completely free to refuse to answer any questions and have the option to end the interview at any time without any consequences or explanation.

Name: _____

Signature of participant _____

Date _____

Please provide your contact information here so we can arrange suitable date and time for the interview.

Contact telephone number:

Email address:

Appendix 6

Information Sheet for Counselling Psychologist Interview

Dear Madam/Sir,

As you have previously consented to be contacted for a follow up research, you are invited to participate in an interview study. The purpose of this research is to explore more fully as to whether and how the role in the family of origin influences therapeutic practice, especially boundaries and empathy. There will be a one-to one interview with the researcher for approximately 60 minutes, as well as 10 minutes for debriefing afterwards. The interview will take place in a private office setting and will be audio recorded in order to allow for transcription and further analysis.

This study is conducted by Isidora Begni a trainee on the Practitioner Doctorate in Counselling Psychology at the University of Wolverhampton (email: i.begni@wlv.ac.uk), under the supervision of Drs. Josephine Chen- Wilson and Yvette Lewis. The objective is to increase awareness about how a counsellor's role in a family of origin might impact on their therapeutic work. The findings would be beneficial to the practitioners' professional development at a variety of levels of training or practice.

Please be assured that the personal information and results will be kept confidential and secured throughout the study. At the end of the research, the data will be stored securely and anonymously for five years. No individual will be identified in any transcript and publication of the results. You are free to withdraw from the study at any time without explanations and any further implications.

If you would like further information about the outcome of the study, please feel free to contact me after July 2011 via email and an abstract will be sent to you. If you wish to take part in the interview, please complete the consent form enclosed and return it to the address specified.

Your help is greatly appreciated.

Yours faithfully,

Isidora Begni

Trainee Counselling Psychologist

University of Wolverhampton

Appendix 7

Parentification Questionnaire

The following statements are possible descriptions of experiences you may have had while growing up. If a statement accurately describes some portion of your childhood experience, that is, the time during which you lived at home with your family (including your teenage years), mark the statement true on your answer sheet. If the statement does not accurately describe your experience, mark it false.

1. I rarely found it necessary for me to do other family members' chores. T F
2. At times I felt I was the only one my mother/father could turn to. T F
3. My family members hardly ever looked to me for advice. T F
4. In my family I often felt called upon to do more than my share. T F
5. I often felt like an outsider in my family. T F
6. I felt most valuable in my family when someone confided in me. T F
7. It seemed like there were enough problems at home without my causing more. T F
8. In my family I thought it best to let people work out their problems on their own. T F
9. I often resented being asked to do certain kinds of jobs. T F
10. In my family it seemed that I was usually the one who ended up being responsible for most of what happened. T F
11. In my mind, the welfare of my family was my first priority. T F
12. If someone in my family had a problem, I was rarely the one they could turn to for help. T F

13. I was frequently responsible for the physical care of some member of my family, i.e., washing, feeding, dressing, etc. T F

14. My family was not the kind in which people took sides. T F

15. It often seemed that my feelings weren't taken into account in my family. T F

16. I often found myself feeling down for no particular reason that I could think of. T F

17. In my family there were certain family members I could handle better than anyone else. T F

18. I often preferred the company of people older than me. T F

19. I hardly ever felt let down by members of my family. T F

20. I hardly ever got involved in conflicts between my parents. T F

21. I usually felt comfortable telling family members how I felt. T F

22. I rarely worried about people in my family. T F

23. As a child I was often described as mature for my age. T F

24. In my family I often felt like a referee. T F

25. In my family I initiated most recreational activities. T F

26. It seemed like family members were always bringing me their problems. T F

27. My parents had enough to do without worrying about housework as well. T F

28. In my family I often made sacrifices that went unnoticed by other family members. T F

29. My parents were very helpful when I had a problem. T F

30. If a member of my family were upset, I would almost always become involved in some way. T F

31. I could usually manage to avoid doing housework. T F

32. I believe that most people understood me pretty well, particularly members of my family. T F

33. As a child, I wanted to make everyone in my family happy. T F

34. My parents rarely disagreed on anything important. T F

35. I often felt more like an adult than a child in my family. T F

36. I was more likely to spend time with friends than with family members. T F

37. Other members of my family rarely needed me to take care of them. T F

38. I was very uncomfortable when things weren't going well at home. T F

39. All things considered, responsibilities were shared equally in my family. T F

40. In my house I hardly ever did the cooking. T F

41. I was very active in the management of my family's financial affairs. T F

42. I was at my best in times of crisis. T F

Appendix 8

INTERPERSONAL REACTIVITY INDEX (IRI)

The following statements ask about your thoughts and feelings in a variety of situations. For each item, show how well it describes you by choosing the appropriate number on the scale at the top of the page: 1, 2, 3, 4, or 5. When you have decided on your answer, fill in the number in the blank next to the item. Read each item carefully before responding and answer as honestly and as accurately as you can.

ANSWER SCALE:

1 2 3 4 5

DOES NOT DESCRIBE ME WELL **DESCRIBES ME VERY WELL**

----- 1. I daydream and fantasize, with some regularity, about things that might happen to me.

----- 2. I often have tender, concerned feelings for people less fortunate than me.

----- 3. I sometimes find it difficult to see things from the "other guy's" point of view.

----- 4. Sometimes I don't feel very sorry for other people when they are having problems.

----- 5. I really get involved with the feelings of the characters in a novel.

----- 6. In emergency situations, I feel apprehensive and ill-at-ease.

----- 7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.

----- 8. I try to look at everybody's side of a disagreement before I make a decision.

----- 9. When I see someone being taken advantage of, I feel kind of protective towards them.

-----10. I sometimes feel helpless when I am in the middle of a very emotional situation.

-----11. I sometimes try to understand my friends better by imagining how things look from their perspective.

-----12. Becoming extremely involved in a good book or movie is somewhat rare for me.

-----13. When I see someone get hurt, I tend to remain calm.

-----14. Other people's misfortunes do not usually disturb me a great deal.

-----15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

-----16. After seeing a play or movie, I have felt as though I were one of the characters.

-----17. Being in a tense emotional situation scares me.

-----18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.

-----19. I am usually pretty effective in dealing with emergencies.

-----20. I am often quite touched by things I see happen.

-----21. I believe that there are two sides to every question and try to look at them both.

-----22. I would describe myself as a pretty soft-hearted person.

-----23. When I watch a good movie, I can very easily put myself in the place of a leading character.

-----24. I tend to lose control during emergencies.

-----25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

-----26. When I'm reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.

-----27. When I see someone who badly needs help in an emergency, I go to pieces.

-----28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.

Appendix 9

Exploitation Index (EI) questions (Epstein & Simon, 1990)

The Exploitation Index: Rate yourself according to the frequency that the following statements reflect your behaviour, thoughts, or feelings with regard to any particular patients you have seen in psychotherapy within the past 2 years, by placing a number in the blank next to the item. Approximate frequency as follows:

1	**2**	**3**	**4**
Never	Rarely	Sometimes	Often

----- 1. Do you find yourself doing any of the following for your family members or social acquaintances: prescribing medication, making diagnoses, offering psychodynamic explanations for their behaviour?

----- 2. Are you gratified by a sense of power when you are able to control a patient's activity through advice, medication, or behavioural restraint? (e.g., hospitalization, seclusion)

----- 3. Do you find the chronic silence or tardiness of a patient a satisfying way of getting paid for doing nothing?

----- 4. Do you accept gifts or bequests from patients?

----- 5. Have you engaged in a personal relationship with patients after treatment was terminated?

----- 6. Do you touch your patients? (exclude handshake)

----- 7. Do you ever use information learned from patients, such as business tips or political information, for your own financial or career gain?

----- 8. Do you feel that you can obtain personal gratification by helping to develop your patient's great potential for fame or unusual achievement?

----- 9. Do you feel a sense of excitement or longing when you think of a patient or anticipate her/his visit?

-----10. Do you make exceptions for your patients, such as providing special scheduling or reducing fees, because you find the patient attractive, appealing, or impressive?

-----11. Do you ask your patient to do personal favours for you? (e.g., get you lunch, mail a letter)

-----12. Do you and your patients address each other on a first-name basis?

-----13. Do you undertake business deals with patients?

-----14. Do you take great pride in the fact that such an attractive, wealthy, powerful, or important patient is seeking your help?

-----15. Have you accepted for treatment persons with whom you have had social involvement or whom you knew to be in your social or family sphere?

-----16. When a patient has been seductive with you, do you experience this as a gratifying sign of your own sex appeal?

-----17. Do you disclose sensational aspects of your patient's life to others? (even when you are protecting the patient's identity)

-----18. Do you accept a medium of exchange other than money for your services? (e.g., work on your office or home, trading of professional services)

-----19. Do you find yourself comparing the gratifying qualities you observe in a patient with the less gratifying qualities in your spouse or significant other? (e.g., thinking: "Where have you been all my life?")

-----20. Do you feel that your patient's problem would be immeasurably helped if only he/she had a positive romantic involvement with you?

-----21. Do you make exceptions in the conduct of treatment-because you feel sorry for your patient, or because you believe that he/she is in such distress or so disturbed that you have no other choice?

-----22. Do you recommend treatment procedures or referrals that you do not believe to be necessarily in your patient's best interests, but that may instead be to your direct or indirect financial benefit?

-----23. Have you accepted for treatment individuals known to be referred by a current or former patient?

-----24. Do you make exceptions for your patient because you are afraid she/he will otherwise become extremely angry or self-destructive?

-----25. Do you take pleasure in romantic daydreams about a patient?

-----26. Do you fail to deal with the following patient behaviours(s): paying the fee late, missing appointments on short notice and refusing to pay for the time (as agreed), seeking to extend the length of sessions?

-----27. Do you tell patients personal things about yourself in order to impress them?

-----28. Do you find yourself trying to influence your patients to support political causes or positions in which you have a personal interest?

-----29. Do you seek social contact with patients outside of clinically scheduled visits?

-----30. Do you find it painfully difficult to agree to a patient's desire to cut down on the frequency of therapy, or to work on termination?

-----31. Do you find yourself talking about your own personal problems with a patient and expecting her/him to be sympathetic to you?

-----32. Do you join in any activity with patients that may serve to deceive a third party? (e.g., insurance company)

Appendix 10

Proposed Interview Questions

This interview aims to explore in depth your experience of parentification in relation to your professional practice. The interview will last approximately 60 minutes, as well as 10 minutes for debriefing afterwards. In terms of protecting anonymity you will be asked to choose a pseudonym to use during the interview, which will also be used during the transcription and data analysis. I would like to ask your permission to record the interview for later transcription.

I would like to remind you that in case of a noticeable distress the interview will be stopped and you will be reminded of your right to withdraw. However, the understanding of how parentification may influence their therapeutic practise may increase your self-awareness and may benefit your professional practice.

For the purpose of this study, a list of questions was generated to guide the interviews, to the extent necessary;

1) To what extent has you role in your family of origin as a child and teenager affected your choice of profession?
2) To what extent has your family role as a child and teenager had an effect on your functioning as a therapist?
3) What is your view on boundary crossing and boundary violation with clients?
4) Have you experienced difficulties with boundary issues with your clients?
5) How has your family role as a child and teenager affected on setting boundaries with clients?
6) What is your view on empathy? What factors do you think contribute to the development of your empathic skills?
7) Have you experienced difficulties to be empathic with your clients?
8) Have you had any concern for the balance between empathy and boundaries setting with your clients?
9) What is your view of parentification?